

296178

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 28930

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove page 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma,

1 - STATE REGISTRAR

REG. NO.

|   |  |   |  |  |   |   |       |
|---|--|---|--|--|---|---|-------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST<br><i>PNINA</i>   | MIDDLE<br>-  | LAST<br><i>ABRAMSON</i>  | 2a DATE OF DEATH<br>MONTH DAY YEAR  | 2b HOUR<br><i>OCT 10, 1985 6:15 PM</i>  |       |
| 3. SEX<br><i>Female</i>   |  | 4. RACE<br><i>White</i>   | 5. DATE OF BIRTH<br>MONTH <i>2</i> DAY <i>4</i> YEAR <i>02</i>     |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>IF UNDER 1 YEAR<br>MONTHS <i>83</i> YRS           | IF UNDER 24 HRS<br>HOURS <i>83</i> MIN.   |       |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><i>Lithuania</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><i>Montgomery</i>  |       |
| 10 CITY OR TOWN OF DEATH<br><i>Rockville</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Hebrew Home of Washington</i> |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Housewife</i>  |   | 12b KIND OF BUSINESS OR INDUSTRY<br><i>Home</i>   |       |
| 13a STATE<br><i>Maryland</i>  |  | 13b COUNTY<br><i>Montgomery</i>   | 13c CITY OR TOWN<br><i>Rockville</i>                               | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 13e STREET ADDRESS / ZIP CODE<br><i>6121 Montrose Rd. 20813</i>   |       |
| 14 FATHER'S NAME<br>FIRST<br><i>Laib</i>  |  | MIDDLE<br>-   | LAST<br><i>Shankman</i>  | 15. MOTHER'S MAIDEN NAME<br>FIRST<br><i>Liebe-Rayzel</i>   |   | MIDDLE<br>-   | LAST  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><i>No</i>   |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><i>N/A</i>  |  | 17. INFORMANT<br><i>Lee R. Abramson</i>  |   | ADDRESS<br><i>4600 Connecticut Ave., NW Washington, D.C. 20008</i>  |       |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>PNEUMONITIS</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <i>SENIILE DEMENTIA</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>5 YEARS</i> |  |   |  |  |   |   |       |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |  |  |   |   |       |
| 19a DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |       |
| 21a. ACCIDENT WAS UNDERLYING<br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <i>19</i>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><i>falling</i>  |   |   |       |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>   |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><i>OCT 10, 1985</i>  |  | 21f LOCATION<br>STREET<br><i>6121 MONTROSE RD, ROCKVILLE</i>   | CITY OR TOWN<br><i>Westwood</i>   | COUNTY<br><i>New Jersey</i>   | STATE |
| 22a. I certify that I (this hospital) attended the deceased from <i>FEB 7, 1984</i> to <i>OCT 10, 1985</i> , that I (we) last saw the deceased alive on <i>OCT 10, 1985</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, in (we) did not view the body after death.   |  |   |  |  |   |   |       |
| 22b. SIGNATURE<br><i>Steven Lipson</i>  |  | DEGREE<br><i>MD</i>   |  | ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                         | 22c. DATE SIGNED<br><i>10/11/85</i>   |   |       |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>STEVEN LIPSON</i>   |  | 22e. ADDRESS<br><i>6121 MONTROSE RD, ROCKVILLE</i>  |  |  |   |   |       |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>   |  | 23b. DATE<br><i>Oct. 13, 1985</i>   | 23c. NAME OF CEMETERY OR CREMATORIAL<br><i>Cedar Park Cemetery</i> |  | 23d. LOCATION<br>CITY OR TOWN<br><i>Westwood</i>                                    | COUNTY<br><i>New Jersey</i>   | STATE |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Ives-Pearson Funeral Homes Falls Church, Va. 22046</i>   |  | 25a. DATE REC'D. BY REGISTRAR AND REGISTRATION SIGNATURE<br><i>Oct. 18, 1985 John Pearson</i>   |  |  |   |   |       |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 may be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |  |  |   |  |  |  |  |  | 8 5 2 8 9 3 1   |  |  |  |
|--|--|--|---|--|--|---|--|--|--|--|--|---|--|--|--|
|  |  |  |   |  |  |   |  |  |  |  |  | REG. NO.  |  |  |  |
| 1 - STATE REGISTRAR  |  |  | 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  | FIRST MIDDLE LAST   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |  | 2b. HOUR  |  |  |  |
|  |  |  | <b>HELEN</b>  |  |  | <b>B. ANDREWS</b>   |  |  | <b>OCTOBER 31, 1985</b>  |  |  | <b>8:12 pm</b>  |  |  |  |
| 3. SEX   |  |  | 4. RACE   |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS                              |  |  |  |
| <b>FEMALE</b>  |  |  | <b>CAUCASIAN</b>  |  |  | <b>JAN 23, 1914</b>   |  |  | <b>71</b>  |  |  | <b>YRS.</b>   |  |  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)   |  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  | MD.   |  |  |  |
| <b>PENNSYLVANIA</b>  |  |  | <b>U.S.A.</b>   |  |  |   |  |  | <b>MONTGOMERY</b>  |  |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |   |  |  |  |
| <b>BROOKVILLE</b>  |  |  | <b>19028 HERITAGE HILLS DRIVE</b>   |  |  |   |  |  | <b>MONT CO. PUBLIC SCHOOLS</b>   |  |  | <b>20901</b>  |  |  |  |
| 13a. STATE   |  |  | 13b. COUNTY   |  |  | 13c. CITY OR TOWN   |  |  | 13d. INSIDE CITY LIMITS?<br><input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 13e. STREET ADDRESS / ZIP CODE                              |  |  |  |
| <b>MARYLAND</b>  |  |  | <b>MONTGOMERY</b>   |  |  | <b>SILVER SPRING</b>  |  |  |  |  |  | <b>10118 TENBROOK DRIVE</b>                                 |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES OR UNKNOWN) <input type="checkbox"/> NO  |  |  | 16b. SOCIAL SECURITY NO.   |  |  | 17. INFORMANT<br>DAUGHTER ADDRESS                           |  |  |  |
|  |  |  |   |  |  |   |  |  | <b>195-03-9872</b>   |  |  | <b>HELEN ANDREWS, BROOKVILLE, MD. 20833</b>                 |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>SHOCK</b>   |  |  |   |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 M</b> |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <b>METASTATIC CANCER</b>  |  |  |   |  |  |   |  |  |  |  |  | <b>3 mos</b>  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>CANCER OF CERUM</b>   |  |  |   |  |  |   |  |  |  |  |  |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |   |  |  |   |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?   |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?                               |  |  |   |  |  |  |
|  |  |  |   |  |  | <input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | <input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)                                     |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7/27</b> , 19 <b>85</b> , to <b>Oct 31</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>Oct 25</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |  |  |   |  |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><i>Stanley A. Schwartz</i>   |  |  | 22c. DEGREE<br><i>MD</i>  |  |  | 22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                        |  |  | 22e. DATE SIGNED<br><b>11/1/85</b>   |  |  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>STANLEY A. SCHWARTZ</b>  |  |  | 22e. ADDRESS<br><b>2101 MEDICAL CENTER DR., SILVER SPRING, MD. 20902</b>                                  |  |  |   |  |  |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  |  | 23b. DATE<br><b>11/4/85</b>   |  |  | 23c. NAME OF CEMETERY OR CREMATORIAL<br><b>FT. LINCOLN</b>  |  |  | 23d. LOCATION<br>CITY OR TOWN<br><b>BRENTWOOD</b>  |  |  | 23e. COUNTY STATE<br><b>PRI GEO MD.</b>                     |  |  |  |
| 24. FUNERAL DIRECTOR <b>FRANCIS J. COLLINS, JR.</b><br>NAME<br><b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 04 1985</b>   |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Jeanne Carlson-Randall</i>   |  |  |  |  |  |   |  |  |  |
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**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|  |  |   |        |   |  |   |                                      |  |          |                          |  |
|--|--|---|--------|---|--|---|--------------------------------------|--|----------|--------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   | FIRST  | MIDDLE  | LAST   | 2a. DATE OF DEATH   | MONTH                                | DAY  | YEAR     | 2b. HOUR                 |  |
|  |  |   | ROBERT | JAMES   | ANTOLIN  | OCTOBER 2, 1985   |                                      |  | 8:35 P M |                          |  |
| 3. SEX   |  | 4. RACE   |        | 5. DATE OF BIRTH  |  |   | 6. AGE (IN YEARS LAST BIRTHDAY)      |  |          | 7. IF UNDER 1 YEAR       |  |
| MALE   |  | WHITE   |        | JUNE 26, 1964   |  |   | 21                                   |  |          | IF UNDER 24 HRS          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |          | MONTHS DAYS HOURS MIN.   |  |
| PA.  |  | USA   |        |   |  |   | MONTGOMERY COUNTY MD.                |  |          |                          |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |        |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |   |                                      | 12b. KIND OF BUSINESS OR INDUSTRY  |          |                          |  |
| BETHESDA   |  | NIH, THE CLINICAL CENTER  |        |   | STUDENT  |   |                                      | 999999 17320   |          |                          |  |
| 13a. STATE   |  | 13b. COUNTY   |        | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                      | 13e. STREET ADDRESS / ZIP CODE   |          |                          |  |
| PENNSYLVANIA   |  |   |        | FAIRFIELD   |  |   |                                      | 66 WAYNESBORO PIKE   |          |                          |  |
| 14. FATHER'S NAME<br>FIRST   |  | MIDDLE  |        | LAST  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST   |                                      | MIDDLE   |          | LAST                     |  |
| VIKTOR   |  |   |        | ANTOLIN   |  | IVANKA  |                                      |  |          | VELIKONJA                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |        | 16c. INFORMANT  |  | 16d. ADDRESS  |                                      | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH  |          |                          |  |
| NO   |  | UNKNOWN   |        | MRS. IVANKA ANTOLIN (MOTHER)  |  | SAME  |                                      | 2 DAYS   |          |                          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>PNEUMONIA</u>   |  |   |        |   |  |   |                                      |  |          |                          |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>ACUTE LEUKEMIA</u>  |  |   |        |   |  |   |                                      |  |          |                          |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |   |        |   |  |   |                                      |  |          |                          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.  |  |   |        |   |  |   |                                      |  |          |                          |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |        |   |  | 20a. AUTOPSY?   |                                      | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |          |                          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |   |                                      |  |          |                          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |        | 21f. LOCATION<br>STREET   |  | CITY OR TOWN  |                                      | COUNTY   |          | STATE                    |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>September 17, 1980</u> to <u>OCTOBER 2, 1985</u> , that <input checked="" type="checkbox"/> (we) last<br>saw the deceased alive on <u>OCTOBER 2, 1985</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated<br>above, <input checked="" type="checkbox"/> we (did) <input checked="" type="checkbox"/> view the body after death. |  |   |        |   |  |   |                                      |  |          |                          |  |
| 22b. SIGNATURE<br><i>Richard L. Heideman</i>   |  | 22c. DEGREE<br><i>MD</i>  |        | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                     |  | 22e. DATE SIGNED<br><i>10-2-85</i>  |                                      |  |          |                          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>RICHARD L. HEIDEMAN</i>  |  | 22e. ADDRESS<br>NATIONAL INSTITUTES OF HEALTH, 9000<br>ROCKVILLE PIKE, BETHESDA, MARYLAND 20205           |        |   |  |   |                                      |  |          |                          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPEC)<br><b>REMOVAL</b>  |  | 23b. DATE<br><b>10/5/85</b>   |        | 23c. NAME OF CEMETERY OR CREMATORIUM<br><b>ST. JOSEPH'S CHURCH</b>  |  | 23d. LOCATION<br>CITY OR TOWN<br><b>EMMITTSBURG</b>   |                                      | COUNTY   |          | STATE<br><b>MARYLAND</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>MARSHALL'S FUN HOME</b>   |  | ADDRESS<br><b>4217 9TH ST. N.WASH. D.C.</b>   |        | 25a. DATE REC'D. BY REGISTRAR<br><b>1485</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Julie Taylor Baker</i>   |                                      |  |          |                          |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by this hospital or attending physician.

10. FUNERAL DIRECTOR: After this certificate has been signed by the medical examiner and completely filled in by the funeral director, page 3 should be detached by value as the burial permit. Then place stamp (burial permit, page 1 and 2) should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, completed by a registered funeral director.

IMPORTANT: If item 21 is marked as item 18, then the medical examiner must be notified of cause.

2025

1990-08-28 08:00:00

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**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

REG. NO.

FOR  
1 - STATE  
REGISTRAR

|  |  |   |                   |  |   |        |  |  |                           |        |                  |   |                                   |
|--|--|---|-------------------|--|---|--------|--|--|---------------------------|--------|------------------|---|-----------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   | FIRST             | MIDDLE   | 1st   | ARIKAT | 2a. DATE OF DEATH                                    | MONTH  | DAY                       | YEAR   | 2b. HOUR         |   |                                   |
|  |  |   |                   |  |   |        | 10   | 29   | 85                        | 0050   | M                |   |                                   |
| 3. SEX   |  | 4. RACE   |                   | 5. DATE OF BIRTH<br>MONTH DAY YEAR   |   |        | 6. AGE (IN YEARS LAST BIRTHDAY)                      |  | IF UNDER 1 YEAR           |        | IF UNDER 24 HRS  |   |                                   |
| Male   |  | White   |                   | October 29, 1985   |   |        | None   |  | YRS.                      | MONTHS | DAYS             | HOURS   | MIN.                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |                   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> N/A DIVORCED <input type="checkbox"/> |   |        | 9. BALTIMORE CITY OR COUNTY OF DEATH                 |  | Montgomery                |        |                  |   | MD.                               |
| Maryland   |  | None  |                   |  |   |        |  |  |                           |        |                  |   |                                   |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |   |        | 12b. KIND OF BUSINESS OR INDUSTRY                    |  |                           |        |                  |   |                                   |
| Rockville  |  | 5049 Shady Grove Adventist Hospital   |                   |  |   |        | None   |  | None                      |        |                  |   |                                   |
| 13a. STATE   |  | 13b. COUNTY   | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   |        | 13e. STREET ADDRESS / ZIP CODE                       |  | 5115 Crossfield Court     |        |                  |   | 12b. KIND OF BUSINESS OR INDUSTRY |
| Maryland   |  | Montgomery  | Rockville         | YES <input checked="" type="checkbox"/>  |   |        | 5115 Crossfield Court                                |  |                           |        |                  |   | 12b. KIND OF BUSINESS OR INDUSTRY |
| 14. FATHER'S NAME  |  | FIRST   | MIDDLE            | LAST   | 15. MOTHER'S MAIDEN NAME  |        |  | FIRST  | MIDDLE                    | LAST   | Alsaadi          |   |                                   |
| Said   |  |   |                   | Arikat   | Amneh   |        |  |  |                           |        |                  |   |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR ORDATES)  |                   | 17. INFORMANT  |   |        | ADDRESS  |  |                           |        |                  |   |                                   |
| No   |  | N/A   |                   | N/A  |   |        | N/A  |  |                           |        |                  |   |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)  |  | Extreme immaturity - 22 weeks   |                   |  |   |        |  |  |                           |        |                  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |                                   |
|  |  |   |                   |  |   |        |  |  |                           |        |                  | 10 minutes                                      |                                   |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause first  |  | DUE TO, OR AS A CONSEQUENCE OF<br>(b) N/A   |                   |  |   |        |  |  |                           |        |                  |   |                                   |
|  |  | DUE TO, OR AS A CONSEQUENCE OF<br>(c) N/A   |                   |  |   |        |  |  |                           |        |                  |   |                                   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |                   |  |   |        |  |  |                           |        |                  |   |                                   |
| N/A  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>N/A   |                   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>    |        |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                           |        |                  |   |                                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY <input type="checkbox"/> EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. N/A 19  |                   |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>N/A |        |  |  |                           |        |                  |   |                                   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> N/A <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>N/A                             |                   |  | 21f. LOCATION<br>STREET<br>CITY OR TOWN<br>COUNTY<br>STATE                              |        |  |  |                           |        |                  |   |                                   |
| 22a. I certify that (I) (this hospital) attended the deceased from 16-29-85 to 16-29-85, that (I) (we) last<br>saw the deceased alive on 16-29-85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death. |  |   |                   |  |   |        |  |  |                           |        |                  |   |                                   |
| 22b. SIGNATURE<br>R. J. Buczek   |  | 22c. DEGREE<br>M.D.   |                   |  | 22d. DATE SIGNED<br>10-30-85  |        |  |  |                           |        |                  |   |                                   |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Robert J. Buczek  |  | 22f. ADDRESS<br>9901 Medical Center Drive, Rockville, MD  |                   |  |   |        |  |  |                           |        |                  |   |                                   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation  |  | 23b. DATE<br>11/29/85   |                   | 23c. NAME OF CEMETERY OR CREMATORIAL<br>Shady Grove Adventist Hospital   |   |        | 23d. LOCATION<br>CITY OR TOWN<br>Rockville           |  | 23e. COUNTY<br>Montgomery |        | 23f. STATE<br>MD |   |                                   |
| 24 FUNERAL DIRECTOR<br>NAME<br>N/A   |  | ADDRESS   |                   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 1 1985   |        | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall |  |                           |        |                  |   |                                   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death or by the physician or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Please sign and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN. The

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(VRA 15, 4)

|  |  |   |  |  |   |  |  |
|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST <b>Carrie</b>   | MIDDLE <b>G.</b>   | LAST <b>Ashworth</b>   | 2a DATE OF DEATH MONTH DAY YEAR   | RECD. NO.  |  |
| 3. SEX<br><b>Female</b>  |  | 4 RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH <b>6</b> DAY <b>21</b> YEAR <b>90</b>              |  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>95</b><br>YRS  |  |
| 7a BIRTHPLACE<br>COUNTRY<br><b>Baltimore, MD</b>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Silver Spring</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Holy Cross Hospital</b> |  |  | 12a USUAL OCCUPATION<br><b>Self-employed</b>  |  |  |
| 13a STATE<br><b>Maryland</b>   |  | 13b COUNTY<br><b>Montgomery</b>   | 13c CITY OR TOWN<br><b>Silver Spring</b>                                     | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e STREET ADDRESS / ZIP CODE<br><b>1948 Seminary Road 20910</b>   |  |
| 14. FATHER'S NAME<br>FIRST <b>John</b>   |  | MIDDLE <b>R.</b>  | LAST <b>Gross</b>  | 15. MOTHER'S MAIDEN NAME<br>MIDDLE <b>Goette</b> LAST  |   |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b SOCIAL SECURITY NO.<br><b>578-50-2923</b>   |  |  | 17 INFORMANT<br><b>Miss Nettie Gross, Sister, Same as #13</b>   |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for 18a, b, and c.)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b>   |  |   |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>As atherosclerotic heart disease</b>   |  |   |  |  |   |  |  |
| { DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b>  |  |   |  |  |   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>C/S B/P</b>  |  |   |  |  |   |  |  |
| 19a DATE OF OPERATION<br><b>6/18/85</b>  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY<br>HOUR A.M. <b>10</b> MONTH <b>AM</b> DAY <b>19</b> YEAR<br>P.M. <b>19</b>  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |   |  |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f LOCATION<br>STREET   | CITY OR TOWN   |   | COUNTY   |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>10/7</b> , 19 <b>85</b> , to <b>10/8</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>10/8</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>DEATH: (I) (we) (did not) (did not) view the body after death. |  |   |  |  |   |  |  |
| 22b SIGNATURE<br><b>David B. Jones</b>   |  | DEGREE<br><b>MD</b>   | ATTENDING PHYSICIAN <input type="checkbox"/>                                 | MEDICAL DIRECTOR <input type="checkbox"/>  | STAFF PHYSICIAN <input type="checkbox"/>  | 22c DATE SIGNED<br><b>10/8/85</b>  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>David B. Jones</b>  |  | 22e ADDRESS<br><b>12012 Veirs Mill Road Columbia, Maryland</b>  |  |  |   |  |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b DATE<br><b>10/11/85</b>   | 23c NAME OF CEMETERY OR CREMATORIAL<br><b>Parklawn Memorial Park</b>         |  | 23d LOCATION<br><b>Rockville, Maryland</b>  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Joseph Gawler's Sons, Inc., 5130 Wisconsin Avenue, N.W., Washington, DC 20016</b>   |  | 25a DATE REC'D. BY REGISTRAR<br><b>OCT 14 1985</b>  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Decker, Jr.</b>                     |  |   |  |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

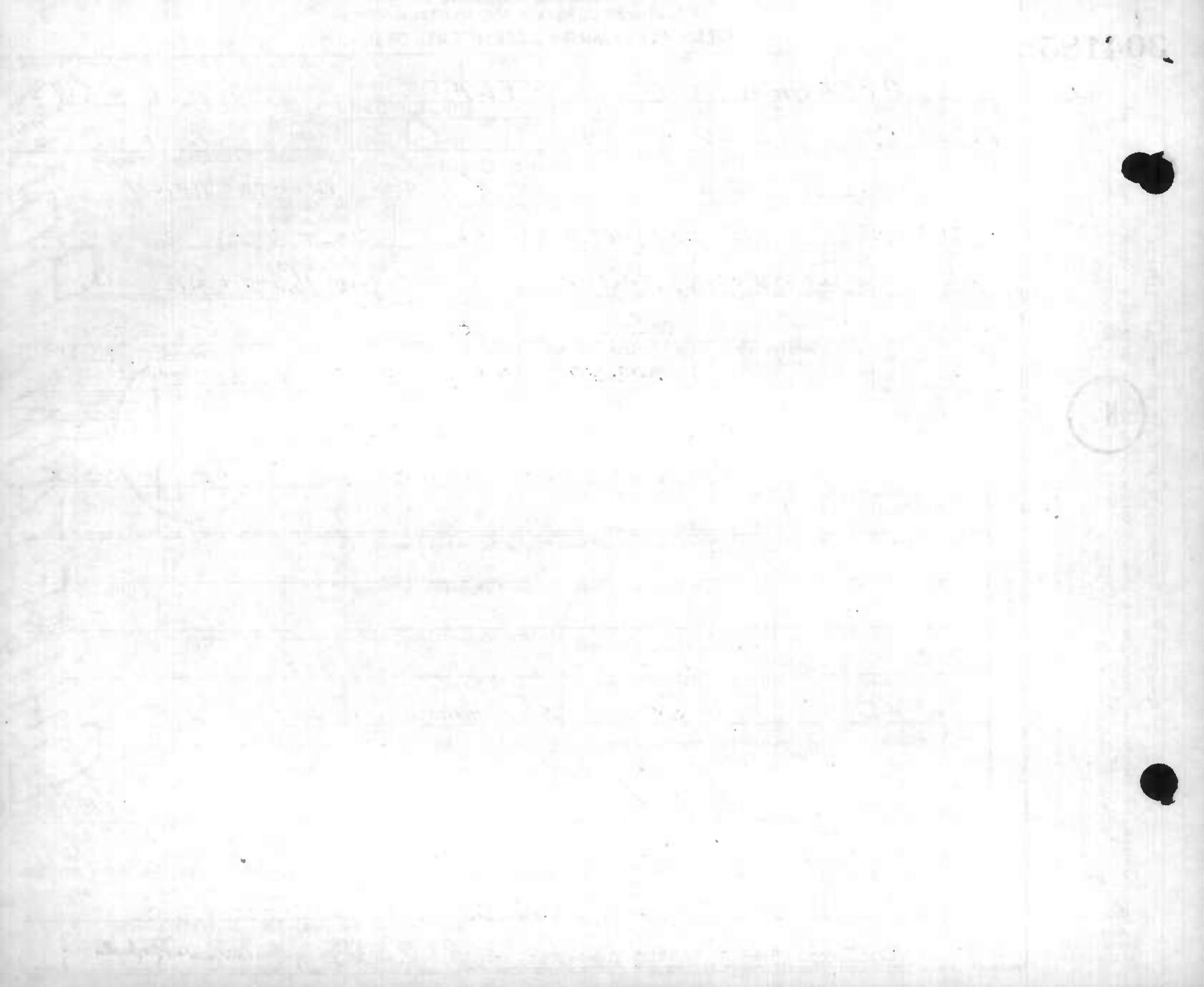
304185 85 28936

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1A. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER LONG WITH FORM PA. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DIVISION OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

|   |         |   |                                    |  |                                  |   |              |
|---|---------|---|------------------------------------|--|----------------------------------|---|--------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |         | FIRST   | MIDDLE                             | LAST   | REG. NO.                         |   |              |
|   |         | <b>ABRAHAM</b>  |                                    |  |                                  |   |              |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH<br>MONTH DAY YEAR  | 6. AGE (IN YEARS<br>LAST BIRTHDAY) | 7. IF UNDER 1 YR.<br>MONTHS DAYS   | 8. IF UNDER 24 HRS.<br>HOURS MIN |   |              |
| Male  | Cauc.   | 12 26 00  | 84 yrs.                            |  |                                  |   |              |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?  |                                    | 8. MARRIED<br>WIDOWED  |                                  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |              |
| Wash., D.C.   |         | USA   |                                    |  |                                  | MONTGOMERY MD   |              |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                  |                                    |  |                                  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)                    |              |
| BETHESDA  |         | 6915 HEATHERHILL RD   |                                    |  |                                  | Owner (Ret) Mens Wear   |              |
| 13a. STATE<br>MD  |         | 13b. COUNTY<br>MONTGOMERY   | 13c. CITY OR TOWN<br>BETHESDA      | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>      |                                  | 13e. STREET ADDRESS<br>6915 HEATHERHILL RD  |              |
| 14. FATHER'S NAME<br>FIRST<br>Simon   |         | MIDDLE  | LAST<br>Atlas                      | 15. MOTHER'S MAIDEN NAME<br>FIRST<br>Ida   |                                  | MIDDLE  | LAST<br>Saul |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>NO   |         | 16b. SOCIAL SECURITY NO.<br>-----   |                                    | 17. INFORMANT<br>Betty A. Siegel; 6915 Heatherhill Road  |                                  | ADDRESS<br>Bethesda, Md. 20817  |              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |         |   |                                    |  |                                  |   |              |
| APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>ACUTE</b>   |         |   |                                    |  |                                  |   |              |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |         |   |                                    |  |                                  |   |              |
| 19a. DATE OF OPERATION  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |                                    |  |                                  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |              |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 10 19 1985  |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>FOUND in Bed</b> |                                  |   |              |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE<br>AT WORK <input checked="" type="checkbox"/>   |         | 21e. PLACE OF INJURY<br>(AT HOME,<br>STREET, FACTORY, FARM, ETC.)<br>Home   |                                    | 21f. LOCATION<br>STREET<br>6915 HEATHERHILL RD   |                                  | CITY OR TOWN<br>Bethesda  |              |
| 21g. I certify that I took charge of the remains described above, held on<br>death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>ACTUAL<br>SIGNATURE<br><i>Francis C. Miller</i>  |         | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> |                                    | and in my opinion<br>TITLE (SPECIFY)<br>M.D. <b>DETT</b> MEDICAL EXAMINER                            |                                  |   |              |
| EXAMINER'S NAME<br>(TYPE OR PRINT)  |         | ADDRESS<br>820 Wisconsin Ave Bethesda Md  |                                    |  |                                  | DATE SIGNED<br>10/19/85<br>20814  |              |
| 23a. BURIAL/CREMATION, REMOVAL<br>(SPECIFY)   |         | 23b. DATE<br>Burial 10-21-1985  |                                    | 23c. NAME OF CEMETERY OR CREMATORIAL<br>Adas Israel Cem.   |                                  | 23d. LOCATION<br>CITY OR TOWN<br>Washington, D.C.                                   |              |
| 24. FUNERAL DIRECTOR<br>NAME<br>Danzansky-Goldberg Chapels  |         | ADDRESS<br>Rockville, Md.   |                                    | 25a. DATE REC'D. BY REGISTRAR<br>OCT 23 1985   |                                  | 25b. REGISTRAR'S SIGNATURE<br><i>Julia Davidson, R.R.</i>                           |              |
| 304185  |         |   |                                    |  |                                  |   |              |



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85 28931

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|  |            |   |                 |  |  |  |                 |  |                 |                                     |      |
|--|------------|---|-----------------|--|--|--|-----------------|--|-----------------|-------------------------------------|------|
| 1 DECEASED NAME<br>(TYPE OR PRINT)   |            | MIDDLE  | LAST            |  | 2a DATE OF DEATH                       | MONTH  | DAY             | YEAR   | 2b HOUR         |                                     |      |
| EDWARD   |            | J.  | AUGUSTINE       |  | 10-12-85                               |  |                 | 8:27 p.m.  |                 |                                     |      |
| 3 SEX  |            | 4 RACE  | 5 DATE OF BIRTH |  | 6 AGE (IN YEARS LAST BIRTHDAY)         |  | IF UNDER 1 YEAR |  | IF UNDER 24 HRS |                                     |      |
| Male   |            | White   | MONTH           | DAY  | YEAR                                   | 57   | YRS             | MONTHS   | DAYS            | HOURS                               | MIN. |
| 7a BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)   |            | 7b CITIZEN OF WHAT COUNTRY?   |                 | 8  |  | MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |                 | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                 | 9 BALTIMORE CITY OR COUNTY OF DEATH |      |
| PENN.  |            | USA   |                 |  |  |  |                 |  |                 | MONTGOMERY MD.                      |      |
| 10 CITY OR TOWN OF DEATH   |            | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                 | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF TIME)  |  | 12b KIND OF BUSINESS<br>INDUSTRY   |                 |  |                 |                                     |      |
| SILVER SPRING  |            | HOLY CROSS HOSPITAL   |                 | ELEC. ENGINEER   |  | ELEC. ENGINEERING  |                 |  |                 |                                     |      |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |            |   |                 |  |  |  |                 |  |                 |                                     |      |
| 13a STATE  | 13b COUNTY | 13c CITY OR TOWN  |                 | 13d INSIDE CITY LIMITS?  |  | 13e STREET ADDRESS / ZIP CODE  |                 |  |                 |                                     |      |
| MD.  | MONT.      | GAITHERSBURG  |                 | YES <input type="checkbox"/>   | NO <input checked="" type="checkbox"/> | 1 DELLCastle COURT 20879   |                 |  |                 |                                     |      |
| 14 FATHER'S NAME   |            | MIDDLE  | LAST            | 15. MOTHER'S MAIDEN NAME   |  |  |                 |  |                 |                                     |      |
| FRANK  |            |   | AUGUSTINE       | GENEVIEVE  |  | 0. KINSKY  |                 |  |                 |                                     |      |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)   |            | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)  |                 | 17 INFORMANT   |  | ADDRESS  |                 |  |                 |                                     |      |
| YES  |            | WWII  |                 | ROBERTA J. AUGUSTINE SAME AS # 13  |  |  |                 |  |                 |                                     |      |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH <u>15 min</u>   |            |   |                 |  |  |  |                 |  |                 |                                     |      |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause last<br>{<br>b) <u>Coronary heart disease</u> 10 yrs   |            |   |                 |  |  |  |                 |  |                 |                                     |      |
| DUE TO, OR AS A CONSEQUENCE OF<br>c) <u></u>   |            |   |                 |  |  |  |                 |  |                 |                                     |      |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a  |            |   |                 |  |  |  |                 |  |                 |                                     |      |
| 19a DATE OF OPERATION  |            | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |                 |  |  | 20a AUTOPSY?   |                 | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?  |                 |                                     |      |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |            | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR  |                 | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                |                 | YES <input type="checkbox"/> NO <input type="checkbox"/>           |                 |                                     |      |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AI WORK <input type="checkbox"/>  |            | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)                                      |                 | 21f LOCATION<br>STREET   |  | CITY OR TOWN   |                 | COUNTY   |                 | STATE                               |      |
| 22a I certify that (I) (this hospital) attended the deceased from <u>10/12 85</u> to <u>10/12 85</u> that (we) last<br>saw the deceased alive on <u>10/12 85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I (we) did not) view the body after death. |            |   |                 |  |  |  |                 |  |                 |                                     |      |
| 22b. SIGNATURE<br><u>BARRY N. ROSENBAUM, M.D.</u>  |            | DEGREE  |                 | ATTENDING MEDICAL STAFF<br>PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |  | 22c DATE SIGNED<br><u>10/12/85</u>   |                 |  |                 |                                     |      |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>BARRY N. ROSENBAUM</u>  |            | 22e ADDRESS<br><u>3720 FARRAGUT AVE.<br/>KENS 116 TOWN, MD. 20895</u>                                     |                 |  |  |  |                 |  |                 |                                     |      |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |            | 23b. DATE   |                 | 23c NAME OF CEMETERY OR CREMATORIAL  |  | 23d LOCATION<br>CITY OR TOWN   |                 | COUNTY   |                 | STATE                               |      |
| BURIAL   |            | OCT. 16, 1985   |                 | GATE OF HEAVEN   |  | SILVER SPRING  |                 | MONT.  |                 | MD.                                 |      |
| 24 FUNERAL DIRECTOR<br>FRANCIS H. BARBER   |            | ADDRESS<br>LAYTONSVILLE, MD. 20879  |                 | 25a DATE REC'D. BY REGISTRAR<br>OCT 17 1985  |  | 25b REGISTRAR'S SIGNATURE  |                 |  |                 |                                     |      |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the attending physician or by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and returned to you, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Please sign and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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Item 19b 1-13-85 cn

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**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH**

REG. NO.

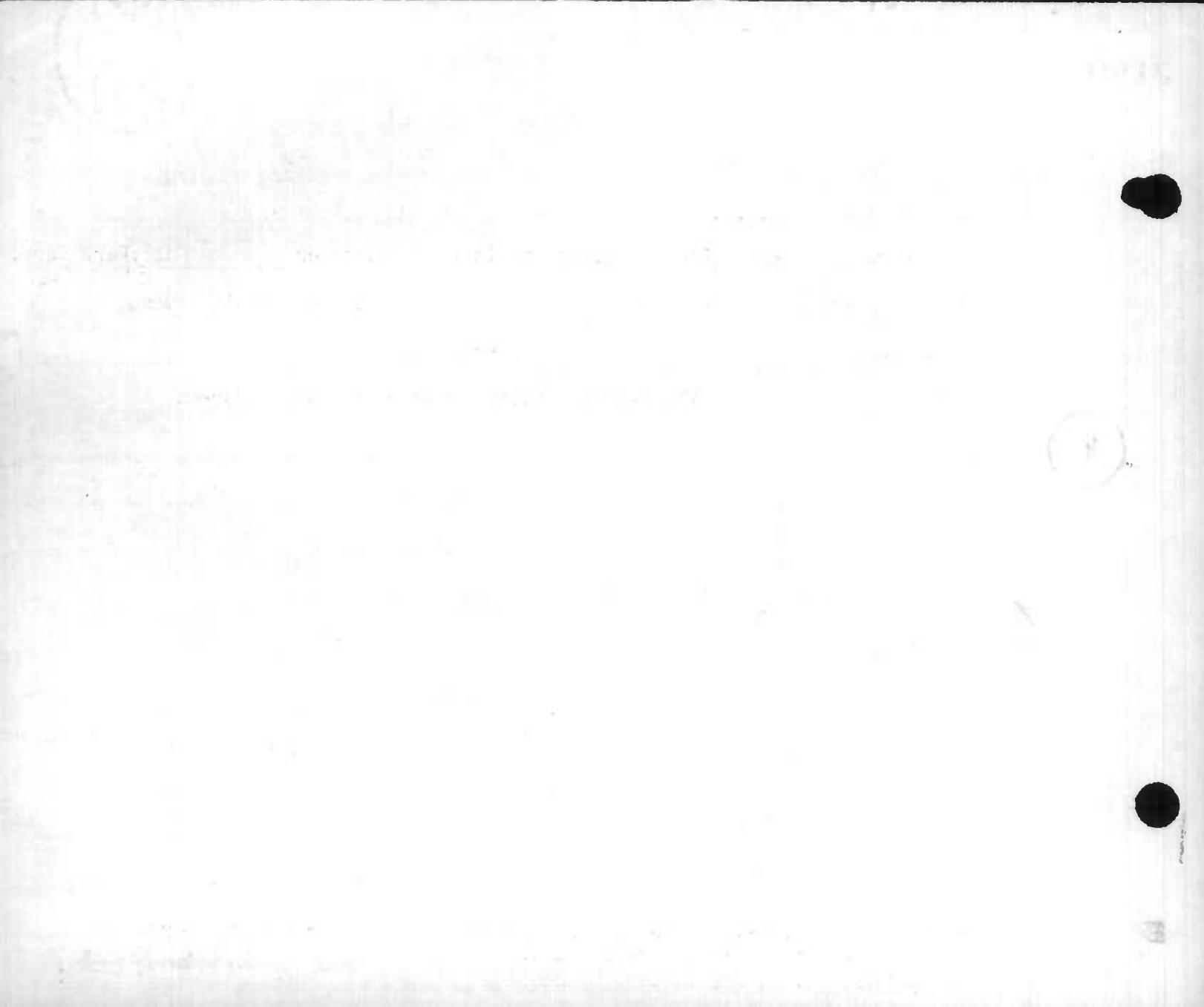
FOR  
1 - STATE  
REGISTRAR

|   |  |   |  |   |   |   |  |  |   |                           |  |  |
|---|--|---|--|---|---|---|--|--|---|---------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   | FIRST<br><i>Gilbert</i>  | MIDDLE  | LAST<br><i>Bacon</i>  | 2a. DATE OF DEATH<br>MONTH DAY YEAR   | MONTH  | DAY  | YEAR  | 2b. HOUR<br>945<br>9 p.m. |  |  |
| 3. SEX<br><i>male</i>   |  | 4. RACE<br><i>Black</i>   | 5. DATE OF BIRTH<br>MONTH<br><i>6</i> DAY<br><i>23</i> YEAR<br><i>37</i> |   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>48</i>  |  |  | IF UNDER 1 YEAR<br>YRS.<br>MONTHS DAYS HOURS MIN. |                           |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>South Carolina</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Montgomery</i>      |   |                           |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Takoma Park</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Washington Adventist Hospital</i> |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Gardener</i>   |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Nat'l. Park Serv.</i>  |   |                           |  |  |
| 13a. STATE<br><i>Maryland</i>   |  | 13b. COUNTY<br><i>Prince George</i>   |  | 13c. CITY OR TOWN<br><i>Landover</i>                            |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><i>1602 Roosevelt Avenue</i> |   | 20783                     |  |  |
| 14. FATHER'S NAME<br>FIRST<br><i>Steven Bacon</i>   |  | MIDDLE  | LAST   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST<br><i>Carrie Key</i>  |   | MIDDLE   | LAST   |   |                           |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><i>217-36-5004</i>   |  |   | 17. INFORMANT<br><i>Lilly Bacon, wife, same address</i>   |   |  | ADDRESS  |   |                           |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and 1c.)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>CARDIAC ARREST</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>RESPIRATORY INSUFFICIENCY</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.                                      |  |   |  |   |   |   |  |  |   |                           |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>ACUTE RESPIRATORY DISTRESS + VARICELA</i>  |  |   |  |   |   |   |  |  |   |                           |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a<br><i>CORONARY ARTERY DISEASE.</i>   |  |   |  |   |   |   |  |  |   |                           |  |  |
| 19a. DATE OF OPERATION<br><i>10/24/85</i>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>MI, Acute Intervention</i>   |  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |                           |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |  |  |   |                           |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |   | 21f. LOCATION<br>STREET   |   | CITY OR TOWN   |  | COUNTY  | STATE                     |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>10/24</i> , 19 <i>85</i> , to <i>10/28</i> , 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>10/28</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |   |   |  |  |   |                           |  |  |
| 22b. SIGNATURE<br><i>Samie Ngimat, MD</i>   |  | 22c. DEGREE   |  |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                             |   |  | 22d. DATE SIGNED<br><i>10/28/85</i>                            |   |                           |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Samie Ngimat, MD</i>  |  | 22e. ADDRESS<br><i>10313 Georgia Av., Silver Spring, MD 20902</i>   |  |   |   |   |  |  |   |                           |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>   |  | 23b. DATE<br><i>Nov. 2, 1985</i>  |  | 23c. NAME OF CEMETERY OR CREMATORIAL<br><i>Harmony Memorial</i> |   | 23d. LOCATION<br>CITY OR TOWN<br><i>Highland Park, Maryland</i>                                 |  | 23e. COUNTY STATE  |   |                           |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>McGuire Funeral Service, Inc.</i>  |  | ADDRESS<br><i>7400 Georgia Ave. NW, Washington, DC 20012</i>  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><i>NOV 7 1985</i>  |   | 25b. REGISTRAR'S SIGNATURE<br><i>J. McGuire</i>  |  |   |                           |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician or attending physician, pages 1 and 2 should be detached for use as the Burial Transit Permit. Then please remember to file a copy of pages 1 and 2 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event,



309013

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|   |  |   |       |  |         |   |       |  |      |  |  |   |  |
|---|--|---|-------|--|---------|---|-------|--|------|--|--|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)  |  |   | FIRST | MIDDLE   | LAST    | 2a DATE OF DEATH  | MONTH | DAY  | YEAR | 2b HOUR  |  |   |  |
|   |  |   | David | M.   | Baldwin | October 31, 1985  |       |  |      | 4:40am   |  |   |  |
| 3 SEX   |  | 4 RACE  |       | 5. DATE OF BIRTH   |         | 6. AGE (IN YEARS LAST BIRTHDAY)                                       |       | IF UNDER 1 YEAR  |      | IF UNDER 24 HRS  |  |   |  |
| Male  |  | Caucasian   |       | Month July Day 31 Year 1912  |         | 73  |       | YRS  |      | MONTHS DAYS HOURS MIN.   |  |   |  |
| 7a BIRTHPLACE<br>COUNTRY  |  | 7b CITIZEN OF WHAT COUNTRY?   |       | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |         | 9 BALTIMORE CITY OR COUNTY OF DEATH                                   |       | MD.  |      |  |  |   |  |
| Illinois  |  | United States   |       |  |         | Montgomery County Maryland  |       |  |      |  |  |   |  |
| 10 CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |       | 12a USUAL OCCUPATION   |         | 12b KIND OF BUSINESS OR<br>(IF NOT IN 12a, GIVE MOST OF WORKING LIFE) |       | 12c ADDRESS  |      |  |  |   |  |
| Bethesda  |  | Suburban Hospital   |       | Traffic Engineer   |         | United States Government  |       | 5101 River Road<br>Bethesda, Maryland 20816  |      |  |  |   |  |
| 13a STATE<br>Maryland   |  |   |       |  |         | 13b COUNTY<br>Montgomery  |       | 13c CITY OR TOWN<br>Bethesda   |      | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e STREET ADDRESS / ZIP CODE<br>Bethesda, Maryland 20816 |  |
| 14 FATHER'S NAME<br>Edward Chuncey Baldwin  |  |   |       |  |         | 15 MOTHER'S MAIDEN NAME<br>Mabel                                      |       |  |      |  |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)  |       | 17 INFORMANT<br>Donald A. Kettlestring 743 Owens Street<br>Rockville, Maryland 20850 (Son in Law)  |         | ADDRESS   |       | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>3 MONTHS  |      |  |  |   |  |
| No  |  | 321-289256  |       |  |         |   |       |  |      |  |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) METASTATIC CARCINOMA  |  |   |       |  |         | 1 year  |       |  |      |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) SQUAMOUS CELL CANCER OF LUNG<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |   |       |  |         |   |       |  |      |  |  |   |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a<br>HYPERCALCEMIA in ASSOCIATION WITH A DOSE  |  |   |       |  |         |   |       |  |      |  |  |   |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |       |  |         | 20a AUTOPSY?  |       | 20b IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>    |      |  |  |   |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |       | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |         |   |       |  |      |  |  |   |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK   |  | 21e PLACE OF INJURY<br>(AT HOME STREET FACTORY, OFFICE, FARM, ETC.)                                       |       | 21f LOCATION<br>STREET   |         | CITY OR TOWN  |       | COUNTY   |      | STATE  |  |   |  |
| 22a I certify that (I) (this hospital) attended the deceased from <u>Sept 20</u> , 19 <u>85</u> , to <u>3/10/86</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>Oct 06</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |       |  |         |   |       |  |      |  |  |   |  |
| 22b SIGNATURE<br><i>Eugene P. Libe MD</i>   |  |   |       |  |         | DEGREE<br>MD  |       | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |      | 22c DATE SIGNED<br>31 Oct 85   |  |   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Eugene P. Libe MD.</i>   |  |   |       |  |         | 22e ADDRESS<br>10810 CONNECTICUT AVE<br>KENSINGTON, MD 20811          |       |  |      |  |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 23b DATE<br>October 31, 1985  |       | 23c NAME OF CEMETERY OR CREMATORIAL<br>Metropolitan Crematory Alexandria Virginia  |         | 23d LOCATION<br>CITY OR TOWN  |       | COUNTY   |      | STATE  |  |   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>Robert A. Pumphrey Funeral Homes PA<br>300 West Montgomery Ave. Rockville, Maryland  |  |   |       |  |         | 25 DATE REC'D. BY REGISTRAR   |       | 25 REGISTRAR'S SIGNATURE<br><i>Jill Davidson-Pendell</i>   |      |  |  |   |  |
| DHMH - 16 60M 7-B4<br>(VRA 15, 4)   |  |   |       |  |         | NOV 01 1985   |       |  |      |  |  |   |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 1 TO THE FUNERAL DIRECTOR.  
 TO FUNERAL DIRECTOR: PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FUNERAL PERMIT, PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGE 4 SHOULD BE RETAINED BY THE CHIEF MEDICAL EXAMINER UNTIL RECORDS ARE FILED. WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

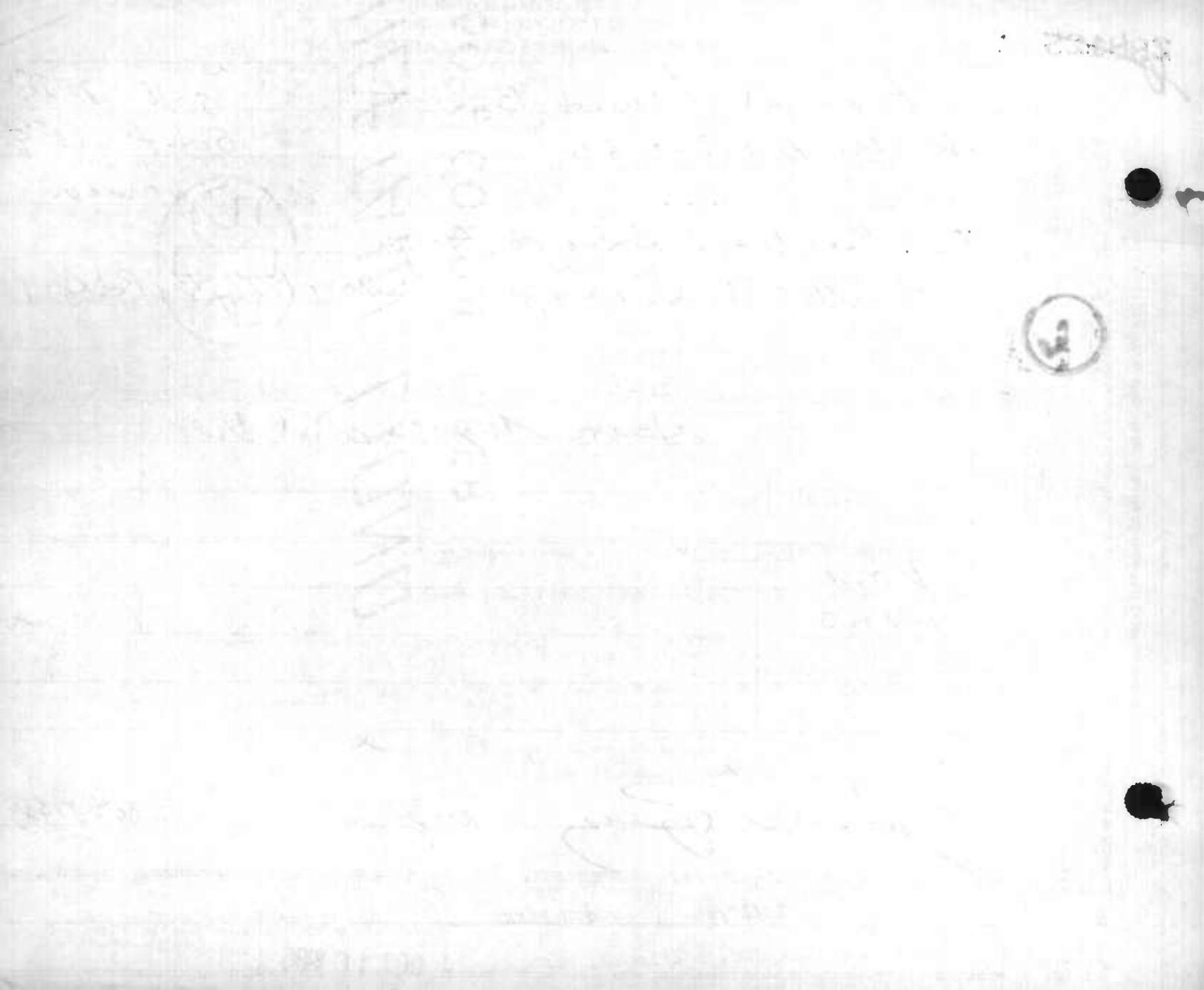
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

85 28940

1 - STATE REGISTRAR

|   |  |  |                                    |   |  |                          |                         |   |  |  |
|---|--|--|------------------------------------|---|--|--------------------------|-------------------------|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST  | MIDDLE                             | LAST  | 2a. DATE KNOWN<br>OF ESTI-<br>DEATH MATED                        | MONTH                    | DAY                     | YEAR  |  |  |
| 1. SEX  |  | 4. RACE  | 5. DATE OF BIRTH<br>MONTH DAY YEAR | 6. AGE (IN YEARS<br>LAST BIRTHDAY)  | IF UNDER 1 YR.   | IF UNDER 24 HRS.         |                         |   |  |  |
|   |  |  |                                    | 60 yrs.   | MONTHS   | DAYS                     | HOURS                   | MIN.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |                                    |   | 8. MARRIED   | <input type="checkbox"/> | NEVER MARRIED           | <input type="checkbox"/>  |  |  |
|   |  | U.S.A.   |                                    |   | WIDOWED  | <input type="checkbox"/> | DIVORCED                | <input checked="" type="checkbox"/>   |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                    |   | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE) |                          |                         | 12b. KIND OF BUSINESS<br>OR INDUSTRY  |  |  |
| 12. STATE   |  | 13b. COUNTY  | 13c. CITY OR TOWN                  | 13d. INSIDE CITY LIMITS?  |  |                          | 13e. STREET ADDRESS     |   |  |  |
| Md  |  | Mont.  | St. L. Spgr                        | YES   | <input type="checkbox"/>   | NO                       | 2094 Pincky Bv Rd Apt 1 |   |  |  |
| 14. FATHER'S NAME<br>FIRST  |  | MIDDLE   | 15. MOTHER'S MAIDEN NAME<br>FIRST  |   |  | MIDDLE                   | Selzman                 |   |  |  |
| Edward  |  | Barrett  | Agnes                              |   |  |                          |                         |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |                                    |   | 17. INFORMANT  |                          |                         | ADDRESS   |  |  |
| NO  |  | 219-10-3913  |                                    |   | Miss Regina Barrett  |                          |                         | 239 So. Exter St  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Scoto Myoc vdist Dici</i>  |  |  |                                    |   |  |                          |                         |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH              |  |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a) stating the under-<br>lying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF  |  |  |                                    |   |  |                          |                         |   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><i>None</i>   |  |  |                                    |   |  |                          |                         |   |  |  |
| 19a. DATE OF OPERATION<br><i>None</i>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |                                    |   |  |                          |                         | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |                          |                         |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)   |                                    | 21f. LOCATION<br>STREET   |  |                          | CITY OR TOWN            | COUNTY  | STATE  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion<br>death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |  |                                    |   |  |                          |                         |   |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><i>Kenneth Edward Barrett</i>   |  |  |                                    |   |  |                          |                         |   | TITLE (SPECIFY)<br>M.D. <i>Ruf</i> MEDICAL EXAMINER          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |  |                                    |   |  |                          |                         |   | 23b. DATE<br>10/12/85  |  |
| 23c. NAME OF CEMETERY OR CREMATORIAL<br>Loudon Park   |  |  |                                    |   |  |                          |                         |   | 23d. LOCATION<br>CITY OR TOWN<br>Baltimore, Maryland         |  |
| 24. FUNERAL DIRECTOR<br>NAME <i>Leonard J Ruck Inc.</i> ADDRESS <i>Baltimore, Maryland</i>  |  |  |                                    |   |  |                          |                         |   | 25a. DATE REC'D. BY REGISTRAR<br>OCT 10 1985                 |  |
|   |  |  |                                    |   |  |                          |                         |   | 25b. REGISTRAR'S SIGNATURE<br><i>Jeanne Anderson Rundall</i> |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

289146

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8528941

|  |                              |   |                      |  |   |                   |   |   |                    |                       |                     |
|--|------------------------------|---|----------------------|--|---|-------------------|---|---|--------------------|-----------------------|---------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |                              |   | FIRST                | MIDDLE   | LAST  | 2a. DATE OF DEATH | MONTH   | DAY   | YEAR               | 2b. HOUR              |                     |
| <i>Theresa A. Barrett</i>  |                              |   |                      |  | <i>BARRETT</i>  | <i>10-9-85</i>    |   |   |                    | <i>8:37 PM</i>        |                     |
| 3. SEX   | 4. RACE                      | 5. DATE OF BIRTH  |                      |  | 6. AGE (IN YEARS LAST BIRTHDAY)   | IF UNDER 1 YEAR   |   |   | 7. IF UNDER 24 HRS |                       |                     |
| <i>Female</i>  | <i>White</i>                 | MONTH   | DAY                  | YEAR   | <i>74</i>   | MONTHS            | DAYS  |   | HOURS              | MIN.                  |                     |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                      |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |                   |   |   |                    |                       |                     |
| <i>NEW YORK</i>  | <i>U.S.A.</i>                |   |                      |  | <i>Montgomery CT, Md.</i>   |                   |   |   |                    |                       |                     |
| 10. CITY OR TOWN OF DEATH  |                              | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)   |                      |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |                   |   |   |                    |                       |                     |
| <i>SILVER SPRING</i>   |                              | <i>HOLY CROSS HOSPITAL</i>  |                      |  | <i>TELEPHONE OPERATOR, JERSEY BELL</i>  |                   |   |   |                    |                       |                     |
| 13a. STATE   |                              | 13b. COUNTY   | 13c. CITY OR TOWN    | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |                   | 13e. STREET ADDRESS / ZIP CODE                      |   |                    |                       |                     |
| <i>MARYLAND</i>  |                              | <i>MONTGOMERY</i>   | <i>SILVER SPRING</i> |  |   |                   | <i>10000 BRUNSWICK AVENUE 20910</i>                 |   |                    |                       |                     |
| 14. FATHER'S NAME  |                              | FIRST   | MIDDLE               | LAST   | 15. MOTHER'S MAIDEN NAME  |                   |   | 16. REED  |                    |                       |                     |
| <i>JAMES</i>   |                              |   |                      | <i>SLADE</i>   |   |                   |   |   |                    |                       |                     |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |                              | 16b. SOCIAL SECURITY NO.  |                      | 17. INFORMANT  |   |                   | 18. APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |   |                    |                       |                     |
| <i>NO</i>  |                              | <i>066-09-2470</i>  |                      | <i>SON</i>   |   |                   | <i>immediate</i>                                    |   |                    |                       |                     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:  |                              | IMMEDIATE CAUSE (a) <i>Cardio pulmonary arrest</i>  |                      |  |   |                   |   |   |                    |                       |                     |
|  |                              | DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Ischemic Heart Disease</i>   |                      |  |   |                   |   |   |                    |                       |                     |
|  |                              | DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>Occlusive Cardiovascular Disease</i>   |                      |  |   |                   |   |   |                    |                       |                     |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |                              |   |                      |  |   |                   |   |   |                    |                       |                     |
| 19a. DATE OF OPERATION   |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                      |  | 20a. AUTOPSY?   |                   |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?                 |                    |                       |                     |
|  |                              |   |                      |  | <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>   |                   |   | <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> |                    |                       |                     |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |                              | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                   |   |   |                    |                       |                     |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>  |                              | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                      |  | 21f. LOCATION<br>STREET   |                   |   | CITY OR TOWN  | COUNTY             | STATE                 |                     |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>October 9, 1985</i> , to <i>October 9, 1985</i> , that (I) (we) last saw the deceased alive on <i>October 9, 1985</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                              |   |                      |  |   |                   |   |   |                    |                       |                     |
| 22b. SIGNATURE<br><i>CHIN CHUAN Hou</i>  |                              | 22c. DEGREE<br><i>M.D.</i>  |                      |  | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                   |   | 22e. DATE SIGNED  |                    |                       |                     |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>CHIN-CHUAN HOU</i>   |                              | 22e. ADDRESS<br><i>6719 Baltimore Ave<br/>Riverdale, MD 20737</i>   |                      |  |   |                   |   |   |                    |                       |                     |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |                              | 23b. DATE<br><i>10/12/85</i>  |                      | 23c. NAME OF CEMETERY OR CREMATORY<br><i>ST. JOHNS CEMETERY</i>                      |   |                   | 23d. LOCATION<br>CITY OR TOWN<br><i>FOREST GLEN</i> |   |                    | COUNTY<br><i>MONT</i> | STATE<br><i>MD.</i> |
| 24. FUNERAL DIRECTOR   |                              | 25a. DATE REC'D. BY REGISTRAR   |                      |  | 25b. REGISTRAR'S SIGNATURE  |                   |   |   |                    |                       |                     |
| <i>FRANCIS J. COLLINS, JR.</i>   |                              |   |                      |  |   |                   |   | <i>Guthrie L. Pendleton</i>   |                    |                       |                     |
|  |                              |   |                      |  |   |                   |   | <i>OCT 14 1985</i>  |                    |                       |                     |

1163

but 50 percentual

Death was the only

adult death which

occurred during the

first year of life.

2. The death rate

of the first year

is 50 percentual

and

200 percentual

287122

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 9 2 8 9 4 2

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|   |  |   |   |   |  |  |   |   |  |         |   |
|---|--|---|---|---|--|--|---|---|--|---------|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   | FIRST   | MIDDLE  | LAST   | 20. DATE OF DEATH  | MONTH   | DAY   | YEAR   | 26 HOUR |   |
| Thomas  |  |   | F.  |   | BAXTER, Sr.  | October 1, 1985  |   |   | 6 P.M.   |         |   |
| 3. SEX  |  | 4. RACE   | 5. DATE OF BIRTH  |   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |   |   | IF UNDER 1 YEAR  |         |   |
| Male  |  | Caucasian   | August 30, 1913   |   |  | 72   |   |   | IF UNDER 24 HRS  |         |   |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |   |   |  |         |   |
| Maryland  |  | USA   |   |   |  | Montgomery County  |   |   | MD.  |         |   |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |   | 12b. KIND OF BUSINESS OR INDUSTRY           |  |         |   |
| Bethesda  |  | Suburban Hospital   |   |   | Retired meter installer PEPCO  |  |   |   |  |         |   |
| 13d. STATE  |  | 13b. COUNTY   | 13c. CITY OR TOWN   |   |  | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |   | 13e. STREET ADDRESS / ZIP CODE                                 |         |   |
| Maryland  |  | Prince Georges  | Landover Hills  |   |  |  |   |   | 4207 70th Avenue 20784   |         |   |
| 14. FATHER'S NAME   |  | FIRST   | MIDDLE  | LAST  | 15. MOTHER'S MAIDEN NAME   |  |   |   |  |         |   |
| Thomas  |  | W.  |   | Baxter  | Carrie   |  |   | Nalley                                      |  |         |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>YES, NO, OR UNKNOWN   |  | (IF YES, GIVE WAR OR DATES)   |   | 16b. SOCIAL SECURITY NO.  | 17. INFORMANT  |  |   | ADDRESS                                     |  |         |   |
| NO  |  | -- -  |   | 577-05-0639   | Connie B. Randall  |  |   | 963 Fall Circle Way<br>Gambrills, Md. 21054 |  |         |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))<br>PART I. DEATH WAS CAUSED BY  |  |   |   |   |  |  |   |   |  |         | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>GASTROINTESTINAL HEMORRHAGE</u> 2 weeks  |  |   |   |   |  |  |   |   |  |         |   |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>PORTAL CIRRHOSIS</u> 1 yr.   |  |   |   |   |  |  |   |   |  |         |   |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |   |   |   |  |  |   |   |  |         |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>None</u>   |  |   |   |   |  |  |   |   |  |         |   |
| 19a. DATE OF OPERATION<br><u>None</u>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   |  |  | 20a. AUTOPSY?   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |         |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2) |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |         |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |   | 21f. LOCATION<br>STREET   |  |  | CITY OR TOWN  |   | COUNTY   |         | STATE   |
| 22a. I certify that (I) this hospital attended the deceased from <u>June 20, 1985</u> to <u>Oct 1, 1985</u> , that (I) (we) last saw the deceased alive on <u>Oct 1, 1985</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (we did) (I did) (we did not) view the body after death. |  |   |   |   |  |  |   |   |  |         | 22c. DATE SIGNED                                |
| 22b. SIGNATURE<br><u>R. Lindeman, M.D.</u> DEGREE   |  |   |   |   |  |  |   |   |  |         | Oct. 2, 1985                                    |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS  |   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22f. DATE SIGNED  |   |  |         |   |
| Dr. Robert J. Lindeman, M.D.  |  | 10215 Fernwood Rd. Bethesda, MD 20817   |   |   |  |  |   |   |  |         |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORIAL  |  |  | 23d. LOCATION<br>CITY OR TOWN                                       |   | COUNTY   |         | STATE   |
| Burial  |  | Oct. 4, 1985  |   | Ft. Lincoln Cemetery  |  |  | Brentwood,  |   | Maryland   |         |   |
| 24. FUNERAL DIRECTOR<br>NAME  |  | 16000 Annapolis Road<br>Bowie, MD 20715-3043  |   |   | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |   |  |         |   |
| Beall Funeral Home  |  |   |   |   | OCT 9 1985   |  |   |   |  |         |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 shows any injury, or other traumatic event, the medical examiner may be summoned to make an examination.

BP \_\_\_\_\_

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and returned to you, it may be detached for use at the burial/transit permit. Then please remove carbon copies, return the original to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certification section must be completed on back.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |                      |  |   |  |        |   | 8 5 2 8 9 4 3                                   |       |              |  |
|---|--|--|---|----------------------|--|---|--|--------|---|---|-------|--------------|--|
|   |  |  |   |                      |  |   |  |        |   | REG. NO.  |       |              |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  | FIRST   | MIDDLE               | LAST   | 2a. DATE OF DEATH   |  |        | MONTH   | DAY   | YEAR  | 2b. HOUR     |  |
| <i>George</i>   |  |  | <i>W.</i>   | <i>Beall, Jr.</i>    |  | <i>10-13-85</i>   |  |        |   |   |       | <i>12 AM</i> |  |
| 3. SEX  |  |  | 4. RACE   | 5. DATE OF BIRTH     | 6. AGE (IN YEARS LAST BIRTHDAY)  | 7. IF UNDER 1 YEAR  |  |        | 8. IF UNDER 24 HRS  |   |       |              |  |
| <i>MALE</i>   |  |  | <i>WHITE</i>  | <i>MARCH 31 1908</i> | <i>77</i>  |   |  |        |   |   |       |              |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)   |  |  | 7b. CITIZEN OF WHAT COUNTRY?  |                      |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |        | 9. BALTIMORE CITY OR COUNTY OF DEATH  |   |       |              |  |
| <i>Washington, D.C.</i>   |  |  | <i>USA</i>  |                      |  |   |  |        | <i>Montgomery</i>   |   |       |              |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                      |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |        | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |   |       |              |  |
| <i>MARY LAND</i>  |  |  | <i>Holy cross Hosp. 1500 Forest Glen Rd.<br/>Silver Spring Md.</i>  |                      |  | <i>Accountant (Ret)</i>   |  |        | <i>Office Manager</i>   |   |       |              |  |
| 13a. STATE  |  |  | 13b. COUNTY   | 13c. CITY OR TOWN    | 13d. INSIDE CITY LIMITS?   | 13e. STREET ADDRESS / ZIP CODE  |  |        |   |   |       |              |  |
| <i>Maryland</i>   |  |  | <i>Montgomery</i>   | <i>Silver Spring</i> | <i>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></i> | <i>102 Univ. Blvd. E.</i>   |  |        | <i>20901</i>  |   |       |              |  |
| 14. FATHER'S NAME<br>FIRST  |  |  | MIDDLE  | LAST                 | 15. MOTHER'S MAIDEN NAME<br>FIRST  |   |  | MIDDLE | LAST  |   |       |              |  |
| <i>George</i>   |  |  | <i>W.</i>   | <i>Beall, Sr.</i>    | <i>Edna</i>  |   |  |        |   | <i>Myers</i>                                    |       |              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |  | 16b. SOCIAL SECURITY NO.  |                      |  | 17. INFORMANT   |  |        | ADDRESS   |   |       |              |  |
| <i>N/A</i>  |  |  | <i>578-40-4786 A</i>  |                      |  | <i>Zea E.P. Beall-wife-</i>   |  |        | <i>(same as 13e)</i>  |   |       |              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a)  |  |  |   |                      |  |   |  |        |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |       |              |  |
| <i>respiratory failure</i>  |  |  |   |                      |  |   |  |        |   | <i>24 hrs</i>                                   |       |              |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>advanced interstitial lung disease</i>   |  |  |   |                      |  |   |  |        |   | <i>5 yrs</i>                                    |       |              |  |
| (c) <i>myocardial insufficiency-congestive heart failure</i>  |  |  |   |                      |  |   |  |        |   |   |       |              |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a  |  |  |   |                      |  |   |  |        |   |   |       |              |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                      |  | 20a. AUTOPSY?   |  |        | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?                 |   |       |              |  |
|   |  |  |   |                      |  | <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |        | <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> |   |       |              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |        |   |   |       |              |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |                      |  | 21f. LOCATION<br>STREET   |  |        | CITY OR TOWN  | COUNTY  | STATE |              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>10-12 1985</i> , to <i>10-13 1985</i> , that (I) <input type="checkbox"/> last<br>saw the deceased alive on <i>10-12 1985</i> , and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated<br>above, (I) <input type="checkbox"/> did not <input type="checkbox"/> view the body after death. |  |  |   |                      |  |   |  |        |   |   |       |              |  |
| 22b. SIGNATURE<br><i>G. Sengstack</i>   |  |  | 22c. DEGREE<br><i>M.D.</i>  |                      |  | ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                                     |  |        | 22d. DATE SIGNED<br><i>10-13-85</i>   |   |       |              |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>G. Sengstack, MD</i>  |  |  | 22f. ADDRESS<br><i>9241 Columbia Blvd. Silver Spring, Md. 20910</i>                                       |                      |  |   |  |        |   |   |       |              |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SUCH AS)  |  |  | 23b. DATE<br><i>10-16-1985</i>  |                      |  | 23c. NAME OF CEMETERY OR CREMATORIAL<br><i>Rock Creek Cemetery</i>  |  |        | 23d. LOCATION<br><i>Washington, DC</i>  |   |       |              |  |
| 24. FUNERAL DIRECTOR<br><i>Hines/Rinaldi Funeral Home</i>   |  |  | 25a. ADDRESS<br><i>11800 N.H. Ave.,<br/>Silver Spring, Md.</i>  |                      |  | 25b. DATE REC'D. BY REGISTRAR<br><i>OCT 15 1985</i>   |  |        | 25b. REGISTRAR'S SIGNATURE<br><i>Jane Davidson-Rendall</i>                        |   |       |              |  |

390123  
4 may be  
in the funeral director, page 3  
filed within 72 hours after death



referred to the hospital or attending physician.

EG100%



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be submitted within 24 hours after death is reported.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician it should be retained for use as the burial/transit permit. Then please remove carbon paper and attach to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 contains any injury, or other traumatic event, the medical certifier must be notified at once.

ITEM NUMBER 4 PER PH. CALL STATE OF MARYLAND  
10-9-85 D.W. DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 28944

FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |                          |   |               |   |       |  |      |                   |  |  |
|---|--|---|--------------------------|---|---------------|---|-------|--|------|-------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   | FIRST                    | MIDDLE  | LAST          | 2a. DATE OF DEATH   | MONTH | DAY  | YEAR | 2b. HOUR          |  |  |
| <i>Mildred</i>  |  |   |                          |   | <i>Beeler</i> | <i>10/14/85</i>   |       |  |      | <i>10:30 P.M.</i> |  |  |
| 3. SEX  |  | 4. RACE   |                          | 5. DATE OF BIRTH<br>MONTH DAY YEAR  |               | 6. AGE (IN YEARS LAST BIRTHDAY)   |       | IF UNDER 1 YEAR  |      | IF UNDER 24 HRS   |  |  |
| <i>Female</i>   |  | <i>White</i>  |                          | <i>09 22 19</i>   |               | <i>66</i>   |       | MONTHS DAYS  |      | HOURS MIN.        |  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |                          | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |               | 9. BALTIMORE CITY OR COUNTY OF DEATH  |       | YRS.   |      |                   |  |  |
| <i>Tennessee</i>  |  | <i>USA</i>  |                          |   |               | <i>Montgomery County</i>  |       |  |      |                   |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                          | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |               | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |       |  |      |                   |  |  |
| <i>Silver Spring</i>  |  | <i>Eaton Manor Health Care Center</i>   |                          |   |               | <i>Housewife</i>  |       |  |      |                   |  |  |
| 13a. STATE  |  | 13b. COUNTY   |                          | 13c. CITY OR TOWN   |               | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |       | 13e. STREET ADDRESS / ZIP CODE   |      | 13f. ZIP CODE     |  |  |
| <i>MD</i>   |  | <i>Montgomery</i>   |                          | <i>Silver Spring</i>  |               | YES <input checked="" type="checkbox"/>   |       | <i>Route 10 London, Kentucky</i>   |      | <i>40553</i>      |  |  |
| 14. FATHER'S NAME   |  | MIDDLE  | 15. MOTHER'S MAIDEN NAME |   |               |   |       |  |      |                   |  |  |
| <i>Arthur</i>   |  |   | <i>Mary</i>              |   |               |   |       |  |      |                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |                          | 17. INFORMANT   |               | ADDRESS   |       | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH  |      |                   |  |  |
| <i>None</i>   |  | <i>408-01-3616</i>  |                          | <i>Betty Beeler (Daughter)</i>  |               | <i>Same as 13E</i>  |       | <i>INSTANT</i>   |      |                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>VENTRICULAR ARRHYTHMIA</i>   |  |   |                          |   |               |   |       |  |      |                   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>CONGESTIVE HEART FAILURE</i> YEARS   |  |   |                          |   |               |   |       |  |      |                   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>ARTERIOSCLEROTIC HEART DISEASE</i> YEARS   |  |   |                          |   |               |   |       |  |      |                   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><i>DIABETES MELLITUS</i>  |  |   |                          |   |               |   |       |  |      |                   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                          |   |               | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |       | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |      |                   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                          | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |               |   |       |  |      |                   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |                          | 21f. LOCATION<br>STREET   |               | CITY OR TOWN  |       | COUNTY   |      | STATE             |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>10/3/85</i> to <i>10/4/85</i> , that (I) we lost<br>sow the deceased alive on <i>10/3/85</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above (I) (we) did not view the body after death. |  |   |                          |   |               |   |       |  |      |                   |  |  |
| 22b. SIGNATURE<br><i>Arthur Beeler</i>  |  | DEGREE<br><i>M.D.</i>   |                          | ATTENDING<br>PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF<br>PHYSICIAN <input type="checkbox"/>                    |               | 22c. DATE SIGNED<br><i>10/15/85</i>   |       |  |      |                   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>MARTIN C. SHAGELL</i>   |  | 22e. ADDRESS<br><i>3720 FAIRFAX AVE<br/>KENSINGTON MD - 20895</i>   |                          |   |               |   |       |  |      |                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>Burial   |  | 23b. DATE<br>10/8/85  |                          | 23c. NAME OF CEMETERY OR CREMATORIAL<br>Roselawn Cemetery   |               | 23d. LOCATION<br>CITY OR TOWN<br>Middlesboro, Kentucky  |       | COUNTY   |      | STATE             |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Hines/Rinaldi</i>  |  | ADDRESS<br>11800 New Hamp. Ave. S.S. Md.  |                          | 25a. DATE REC'D. BY REGISTRAR<br>OCT 7 1985   |               | 25b. REGISTRAR'S SIGNATURE<br><i>Jeanne Sundson-Pendell</i>                                     |       |  |      |                   |  |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 201. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1, 2, 3, AND 4 CAN BE USED AS A BURIAL, CREMATION, OR REMOVAL AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MD. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

28445

## 1 - STATE REGISTRAR Gertrude Belasco MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |         |  |                                    |   |                                   |   |  |  |  |                                      |          |
|--|---------|--|------------------------------------|---|-----------------------------------|---|--|--|--|--------------------------------------|----------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         |  | FIRST                              | MIDDLE  | LAST                              | 2a. DATE KNOWN<br>OF ESTI-<br>DEATH MATED   |  |  |  | MONTH DAY YEAR                       | 11. HOUR |
| <i>Gertrude Belasco</i>  |         |  |                                    |   |                                   | Oct. 23, 1985   |  |  |  | 10:15 AM                             | 12:00 PM |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH<br>MONTH DAY YEAR   | 6. AGE (IN YEARS<br>LAST BIRTHDAY) | 7. IF UNDER 1 YR.<br>MONTHS DAYS  | 8. IF UNDER 24 HRS.<br>HOURS MIN. | 2c. DATE<br>PRONOUNCED<br>DEAD  |  |  |  | MONTH DAY YEAR                       | 12. HOUR |
| Female   | White   | Sept. 23 18  | 75 yrs.                            |   |                                   | Oct. 23, 1985   |  |  |  | 10:15 AM                             | 12:00 PM |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |                                    | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                   | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |  |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY |          |
| New York   |         | U. S. A.   |                                    |   |                                   | <i>Montgomery</i> MD.   |  |  |  | -----                                |          |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                    |   |                                   | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)                                |  |  |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY |          |
| <i>S. L. S.</i>  |         | <i>St. Luke's Convalescent Hosp.</i>   |                                    |   |                                   | Housewife   |  |  |  | -----                                |          |
| 13a. STATE<br>Maryland   |         | 13b. COUNTY<br>Montgomery  |                                    | 13c. CITY OR TOWN<br>Bethesda   |                                   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>6901 Whittier Blvd. (20817) |  | 12. KIND OF BUSINESS<br>OR INDUSTRY  |          |
| 14. FATHER'S NAME<br>FIRST<br>David  |         | MIDDLE   |                                    | LAST<br>Pollack   |                                   | 15. MOTHER'S MAIDEN NAME<br>Minna   |  |  |  | (Unknown)                            |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |         | 16b. SOCIAL SECURITY NO.   |                                    | 17. INFORMANT<br>(Son) ADDRESS<br>Howard Belasco; 499 East 18th St.; Brooklyn,  |                                   |   |  |  |  |                                      |          |
| NO   |         | 080-40-8094  |                                    |   |                                   |   |  |  |  |                                      |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><br>888 IMMEDIATE CAUSE (a) <i>Chronic Obstructive Pul. Dis.</i><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>+ Multiple Myeloma</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |         |  |                                    |   |                                   |   |  |  |  |                                      |          |
| APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH  |         |  |                                    |   |                                   |   |  |  |  |                                      |          |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.<br><br><i>Erect. l. hip</i>   |         |  |                                    |   |                                   |   |  |  |  |                                      |          |
| 19a. DATE OF OPERATION<br>10-18-85   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?<br><i>Erect. l. hip</i>                                  |                                    |   |                                   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |  |  |  |                                      |          |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH   |         | 21b. TIME OF INJURY<br>P.M. 10/11/85   |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><i>Fall at home.</i>   |                                   |   |  |  |  |                                      |          |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>   |         | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)<br><i>Home</i>                              |                                    | 21f. LOCATION<br>STREET<br><i>Whittier Blvd</i>   |                                   | CITY OR TOWN<br><i>Bethesda</i>   |  | COUNTY<br><i>Maryland</i>                          |  | STATE                                |          |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |         |  |                                    |   |                                   |   |  |  |  |                                      |          |
| ACTUAL<br>SIGNATURE<br><i>John S. Rogers</i>   |         | M.D.   |                                    | TITLE (SPECIFY)<br><i>John S. Rogers, M.D.</i>  |                                   | MEDICAL EXAMINER  |  |  |  | DATE<br>SIGNED<br>Oct 25 1985        |          |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |         | ADDRESS<br>1919 Seminary Road; Silver Spring   |                                    |   |                                   | Maryland 20910  |  |  |  |                                      |          |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |         | 23b. DATE<br>10/27/85  |                                    | 23c. NAME OF CEMETERY OR CREMATORIAL<br>Beth David Cemetery   |                                   | 23d. LOCATION<br>CITY OR TOWN<br><i>Elmont</i>  |  | COUNTY<br><i>Long Island</i>                       |  | STATE<br><i>N.Y.</i>                 |          |
| 24. FUNERAL DIRECTOR<br>NAME<br>DANZANSKY-GOLDBERG MEM. CHAPELS<br>1170 Rockville Pike; Rockville, Md. 20852   |         | ADDRESS  |                                    |   |                                   | 25a. DATE REC'D. BY REGISTRAR<br>OCT 28 1985  |  | 25b. REGISTRAR'S SIGNATURE<br><i>John Belasco</i>  |  |                                      |          |

201206

201206

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

304175

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 and 4 should be detached for use as the burial permit. Then please remember to return to the State Dept. of Health and Mental Hygiene, Bureau of Vital Statistics, 5130 Wisconsin Avenue, N.W., Washington, D.C. 20016, within 72 hours after death.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |       |   |      |   |       |   |      | REG. NO.        |      |       |      |
|---|--|--|-------|---|------|---|-------|---|------|-----------------|------|-------|------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  | FIRST | MIDDLE  | LAST | 20. DATE OF DEATH   | MONTH | DAY   | YEAR | 2b HOUR         |      |       |      |
| <i>FLORENCE BENSWANGER</i>  |  |  |       |   |      | 10  | 17    | 85  |      | 7:10P.M.        |      |       |      |
| 3. SEX  |  | 4. RACE  |       | 5. DATE OF BIRTH  |      | 6. AGE (IN YEARS LAST BIRTHDAY)   |       | IF UNDER 1 YEAR   |      | IF UNDER 24 HRS |      |       |      |
| Female  |  | White  |       | Jan. 14, 1891   |      | 93  |       | 94  | YRS  | MONTHS          | DAYS | HOURS | MIN. |
| 7a BIRTHPLACE<br>(COUNTRY)<br><b>Pennsylvania</b>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |       | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b>                                       |       | MD.   |      |                 |      |       |      |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Fernwood House</b> |       | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>  |      | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>  |       |   |      |                 |      |       |      |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Montgomery</b>   |       | 13c. CITY OR TOWN<br><b>Bethesda</b>  |      | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |       | 13e. STREET ADDRESS / ZIP CODE<br><b>6530 Democracy Boulevard</b> |      | <i>20417</i>    |      |       |      |
| 14. FATHER'S NAME<br>FIRST<br><b>Max</b>  |  | MIDDLE<br><b>Rothschild</b>  |       | 15. MOTHER'S MAIDEN NAME<br>FIRST<br><b>Phoebe</b>  |      | MIDDLE<br><b>Farjeon</b>  |       | LAST<br><b>FarJeon</b>  |      |                 |      |       |      |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>182-36-5230</b>  |       | 17. INFORMANT<br><b>Mrs. Jeanne B. Bendheim, Daughter</b><br><b>4956 Sentinel Drive, Apt. 302, Bethesda, MD</b>   |      | ADDRESS   |       |   |      |                 |      |       |      |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a)   |  |  |       | Acute Myocardial Infarction   |      | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>24 hrs.</b>                               |       |   |      |                 |      |       |      |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last   |  | (b) <b>Coronary Atherosclerosis</b>  |       | (c) <b>Generalized Atherosclerosis</b>  |      |   |       |   |      |                 |      |       |      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |       |   |      |   |       |   |      |                 |      |       |      |
| Chronic Brain Syndrome  |  |  |       |   |      |   |       |   |      |                 |      |       |      |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |       | 20a. AUTOPSY?   |      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?                                  |       |   |      |                 |      |       |      |
|   |  |  |       | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |      | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                             |       |   |      |                 |      |       |      |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |      |   |       |   |      |                 |      |       |      |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)  |       | 21f. LOCATION<br>STREET   |      | CITY OR TOWN  |       | COUNTY  |      | STATE           |      |       |      |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on <b>10-17 1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |  |  |       |   |      |   |       |   |      |                 |      |       |      |
| 22b. SIGNATURE<br><i>William Kurstin MD</i>   |  | DEGREE   |       | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |      | 22c. DATE SIGNED<br><b>10/17/85</b>   |       |   |      |                 |      |       |      |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>William Kurstin</b>   |  | 22e. ADDRESS<br><b>1145 19th St. NW WASH. DC 20036</b>   |       |   |      |   |       |   |      |                 |      |       |      |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>10/20/85</b>   |       | 23c. NAME OF CEMETERY OR CREMATORIAL<br><b>Westview Cemetery</b>  |      | 23d. LOCATION<br><b>Pittsburgh, Pennsylvania</b>  |       |   |      |                 |      |       |      |
| 24. FUNERAL DIRECTOR<br><b>Joseph Gawler's Sons, Inc., 5130 Wisconsin Avenue, N.W., Washington, DC 20016</b>  |  |  |       | 25a. DATE REC'D. BY REGISTRAR   |      | 25b. REGISTRAR'S SIGNATURE<br><i>Lila Knudsen Pendell</i>                                       |       |   |      |                 |      |       |      |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1, AND 3 TO THE FUNERAL DIRECTOR.

PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |         |  |                                    |  |   |                                    |  |   |                               |  | 28947   |              |   |  |                          |  |
|---|--|---------|--|------------------------------------|--|---|------------------------------------|--|---|-------------------------------|--|---|--------------|---|--|--------------------------|--|
|   |  |         |  |                                    |  |   |                                    |  |   |                               |  | REG. NO.  |              |   |  |                          |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |         | FIRST  |                                    |  | MIDDLE  |                                    |  | LAST  |                               |  | 2a. DATE KNOWN<br>OF ESTI-<br>DEATH<br>MATED  |              | 2b. MONTH<br>DAY<br>YEAR                            |  |                          |  |
| David W. Berkowitz  |  |         |  |                                    |  |   |                                    |  |   |                               |  | <input type="checkbox"/> Oct. 21, 1985  |              | 9 AM  |  |                          |  |
| 3. SEX  |  | 4. RACE |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR |  |   | 6. AGE (IN YEARS<br>LAST BIRTHDAY) |  |   | IF UNDER 1 YR.<br>MONTHS DAYS |  | IF UNDER 24 HRS.<br>HOURS MIN.  |              | 2c. DATE<br>PRONOUNCED<br>DEAD                      |  | 2d. MONTH<br>DAY<br>YEAR |  |
| M   |  | W       |  | Nov. 16 1921                       |  |   | 63 yrs.                            |  |   |                               |  |   |              | Oct. 21, 1985                                       |  | 9 AM                     |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)  |  |         | 7b. CITIZEN OF WHAT COUNTRY?   |                                    |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED<br>WIDOWED <input type="checkbox"/> DIVORCED |                                    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |                               |  |   |              |   |  |                          |  |
| New York  |  |         | U. S. A.   |                                    |  |   |                                    |  | Montgomery MD.  |                               |  |   |              |   |  |                          |  |
| 10. CITY OR TOWN OF DEATH   |  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                    |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)  |                                    |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY  |                               |  |   |              |   |  |                          |  |
| Olney   |  |         | Mont. General Hosp   |                                    |  | Wholesaler  |                                    |  | Jobber  |                               |  |   |              |   |  |                          |  |
| 13a. STATE<br>Maryland  |  |         | 13b. COUNTY<br>Howard  |                                    |  | 13c. CITY OR TOWN<br>Columbia   |                                    |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                               | 13e. STREET ADDRESS<br>6007 Apt. # 3 Majors Lane |   |              |   |  |                          |  |
| 14. FATHER'S NAME<br>FIRST<br>Isaac   |  |         | MIDDLE   |                                    |  | LAST<br>Berkowitz   |                                    |  | 15. MOTHER'S MAIDEN NAME<br>FIRST<br>Sophie   |                               | MIDDLE   |   | LAST<br>Katz |   |  |                          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <input checked="" type="checkbox"/> Yes   |  |         | 16b. SOCIAL SECURITY NO.<br>WW 2   |                                    |  | 17. INFORMANT<br>Edith Berkowitz (Same as # 13)   |                                    |  | ADDRESS   |                               |  |   |              |   |  |                          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute myocardial Dis-</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a) stating the <u>under-</u><br><u>lying cause lost.</u>  |  |         |  |                                    |  |   |                                    |  |   |                               |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                     |              |   |  |                          |  |
| (b) <u></u><br>DUE TO, OR AS A CONSEQUENCE OF   |  |         |  |                                    |  |   |                                    |  |   |                               |  |   |              |   |  |                          |  |
| (c) <u></u>   |  |         |  |                                    |  |   |                                    |  |   |                               |  |   |              |   |  |                          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><u>None</u>   |  |         |  |                                    |  |   |                                    |  |   |                               |  |   |              |   |  |                          |  |
| 19a. DATE OF OPERATION<br><u>None</u>   |  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |                                    |  |   |                                    |  |   |                               |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |              |   |  |                          |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                             |                                    |  |   |                               |  |   |              |   |  |                          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |         | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)   |                                    |  | 21f. LOCATION<br>STREET   |                                    |  | CITY OR TOWN  |                               | COUNTY   |   | STATE        |   |  |                          |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion<br>death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |         |  |                                    |  |   |                                    |  |   |                               |  |   |              |   |  |                          |  |
| ACTUAL<br>SIGNATURE<br><u>John S. Rogers</u>  |  |         | TITLE (SPECIFY)<br>M.D. <u>John S. Rogers</u>  |                                    |  |   |                                    |  |   |                               |  | DATE SIGNED<br><u>Oct. 21, 1985</u>   |              |   |  |                          |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)  |  |         | MEDICAL EXAMINER   |                                    |  |   |                                    |  |   |                               |  |   |              |   |  |                          |  |
| John S. Rogers, M. D.   |  |         | 1919 Seminary Road, Silver Spring, Md.   |                                    |  |   |                                    |  |   |                               |  |   |              |   |  |                          |  |
| ADDRESS   |  |         |  |                                    |  |   |                                    |  |   |                               |  |   |              |   |  |                          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  |         | 23b. DATE<br><u>BURIAL</u> 1/23/1985   |                                    |  | 23c. NAME OF CEMETERY OR CREMATORIAL<br>ADDRESS   |                                    |  | 23d. LOCATION<br><u>ARLINGTON, VIRGINIA</u>   |                               |  |   |              |   |  |                          |  |
| DONATED TO STEIN HEBREW MEMORIAL FUNERAL HOME<br>232 N CARROLL STREET, N. W., WASHINGTON, D. C.   |  |         |  |                                    |  |   |                                    |  |   |                               |  | 23e. DATE REC'D. BY REGISTRAR   |              | 23f. REGISTRAR'S SIGNATURE<br><u>John S. Rogers</u> |  |                          |  |

SEARCHED

SEARCHED

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

302027

REG. NO.

1 - STATE  
REGISTRAR

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3 RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

|  |        |  |                                   |   |   |                     |  |                                      |                                      |   |  |
|--|--------|--|-----------------------------------|---|---|---------------------|--|--------------------------------------|--------------------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |        | FIRST  | MIDDLE                            | LAST  | 2a. DATE KNOWN<br>OF<br>DEATH<br>ESTI-<br>MATED   | MONTH               | DAY  | YEAR                                 | 2b. HOUR<br>9:00 AM                  |   |  |
| 1c. SEX  | 4 RACE | S. DATE OF BIRTH<br>MONTH DAY YEAR   | 6 AGE (IN YEARS<br>LAST BIRTHDAY) | IF UNDER 1 YR.<br>MONTHS DAYS   | IF UNDER 24 HRS.<br>HOURS MIN.  |                     |  |                                      |                                      |   |  |
| Male   | Cau    | 09 10 95   | 90 yrs.                           |   |   |                     |  |                                      |                                      |   |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)   |        | 7b. CITIZEN OF WHAT COUNTRY?   |                                   |   | MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>              |                     | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH |   |  |
| PENNSYLVANIA   |        | USA  |                                   |   |   |                     |  |                                      | MONTGOMERY MD                        |   |  |
| 10. CITY OR TOWN OF DEATH  |        | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                   |   | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)                                |                     |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY |                                      |   |  |
| OLNEY  |        | Montgomery General Hosp  |                                   |   | ENGINEER  |                     |  | ENGINEERING                          |                                      |   |  |
| 13a. STATE   |        | 13b. COUNTY  |                                   | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS |  |                                      |                                      |   |  |
| NEW JERSEY   |        | ESSEX COUNTY   |                                   | LIVONIAN  |   | 11 TOWER ROAD       |  |                                      |                                      |   |  |
| 14. FATHER'S NAME  |        | FIRST  | MIDDLE                            | LAST  | 15. MOTHER'S MAIDEN NAME  |                     |  |                                      |                                      |   |  |
| ALBERT   |        | -  |                                   | BINDER  | EMMA  |                     | KULL   |                                      |                                      |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |        | 16b. SOCIAL SECURITY NO.   |                                   |   | 17. INFORMANT   |                     | ADDRESS  |                                      |                                      |   |  |
| YES  |        | 135-05-9478  |                                   |   | DOROTHY E. BINDER   |                     | SAME AS #13.   |                                      |                                      |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:   |        | ACUTE MYOCARDIAL DISEASE   |                                   |   |   |                     |  |                                      |                                      | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                     |  |
| IMMEDIATE CAUSE (a)  |        | Acute myocardial disease   |                                   |   |   |                     |  |                                      |                                      | minutes   |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |        |  |                                   |   |   |                     |  |                                      |                                      |   |  |
| (b)  |        | Arteriosclerotic cardiovascular Disease  |                                   |   |   |                     |  |                                      |                                      | years   |  |
| (c)  |        |  |                                   |   |   |                     |  |                                      |                                      |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a  |        |  |                                   |   |   |                     |  |                                      |                                      |   |  |
| History of abdominal aortic aneurysm   |        |  |                                   |   |   |                     |  |                                      |                                      |   |  |
| 19a. DATE OF OPERATION   |        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |                                   |   |   |                     |  |                                      |                                      | 20. AUTOPSY?  |  |
| N/A  |        |  |                                   |   |   |                     |  |                                      |                                      | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |        | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |                                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |   | N/A                 |  |                                      |                                      |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |        | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)   |                                   | 21f. LOCATION<br>STREET   |   | CITY OR TOWN        |  | COUNTY                               | STATE                                |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |        |  |                                   |   |   |                     |  |                                      |                                      |   |  |
| ACTUAL<br>SIGNATURE  |        | TITLE (SPECIFY)<br><i>Paul A. DeVore M.D.</i>  |                                   |   |   |                     |  |                                      |                                      | MEDICAL EXAMINER  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |        | ADDRESS<br>4203 Queensbury Rd Hyattsville MD   |                                   |   |   |                     |  |                                      |                                      | DATE SIGNED<br>10/20/85   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |        | 23b. DATE  |                                   | 23c. NAME OF CEMETERY OR CREMATORIAL  |   |                     | 23d. LOCATION<br>CITY OR TOWN                                      |                                      | COUNTY                               | STATE   |  |
| cremation  |        | Oct. 21, 1985  |                                   | CHAMBERS CREMATORY  |   |                     | RIVERDALE PG CO.   |                                      | MARYLAND                             |   |  |
| 24. FUNERAL DIRECTOR<br>NAME   |        | ADDRESS  |                                   | 25a. DATE REC'D. BY REGISTRAR   |   |                     | 25b. REGISTRAR'S SIGNATURE   |                                      |                                      |   |  |
| CHAMBERS FUNERAL HOME  |        | Silver Spring MD.  |                                   | OCT 25 1985   |   |                     |  |                                      |                                      |   |  |

150508

Santa Cruz Mountains

Op. 70 of FS 1-20-1968

Vermilion

100' above stream, 1/2 mile N. San Simeon

Soil: Reddish brown loam, very poor drainage

Soil: Reddish brown loam

All experimental work done

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be delivered for use in the burial permit. Then please remove carbon paper. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT:

Within 24 hours after death, page 4 may be completed and completely filled in by the funeral director. Page 3 should be filed within 72 hours after death.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |             |   |   |                                   |  |                                      |  |   | 8528949   |                                   |
|---|--|-------------|---|---|-----------------------------------|--|--------------------------------------|--|---|---|-----------------------------------|
|   |  |             |   |   |                                   |  |                                      |  |   | REG. NO.  |                                   |
| 1 - STATE REGISTRAR   |  |             | 2a. DATE OF DEATH   |   |                                   |  |                                      |  |   | 2b. HOUR  |                                   |
| 1c. DECEASED NAME<br>(TYPE OR PRINT)  |  |             | FIRST   | MIDDLE  | LAST                              | MONTH  | DAY                                  | YEAR   |   | 4:50A   |                                   |
| Theresa Oakley Bishop   |  |             |   |   |                                   | October  | 12                                   | 1985   |   |   |                                   |
| 3 SEX   |  |             | 4. RACE   | 5. DATE OF BIRTH  |                                   |  | 6. AGE (IN YEARS LAST BIRTHDAY)      |  |   | 7a. IF UNDER 1 YEAR<br>MONTHS DAYS  | 7b. IF UNDER 24 HRS<br>HOURS MIN. |
| Female  |  |             | Caucasian   | MONTH   | DAY                               | YEAR   | 61                                   |  |   |   |                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |             | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |                                   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |   | MD  |                                   |
| New York  |  |             | United States   | WIDOWED <input type="checkbox"/>  | DIVORCED <input type="checkbox"/> | Montgomery County  |                                      |  |   |   |                                   |
| 10. CITY OR TOWN OF DEATH   |  |             | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |                                   |  |                                      |  |   | 12a. USUAL OCCUPATION<br>(TYPE OR PRINT) 12b. KIND OF BUSINESS OR INDUSTRY  |                                   |
| Bethesda  |  |             | 9309 East Parkhill Drive  |   |                                   |  |                                      |  |   | Property Manager Real Estate  |                                   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |             |   |   |                                   |  |                                      |  |   | 20814   |                                   |
| 13a. STATE  |  | 13b. COUNTY |   | 13c. CITY OR TOWN   |                                   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                      |  | 13e. STREET ADDRESS / ZIP CODE                                |   |                                   |
| Maryland  |  | Montgomery  |   | Bethesda  |                                   |  |                                      |  | 9309 East Parkhill Drive                                      |   |                                   |
| 14. FATHER'S NAME   |  |             | FIRST   | MIDDLE  | LAST                              | 15. MOTHER'S MAIDEN NAME   |                                      |  | MIDDLE  | LAST  |                                   |
| John Thomas Oakley  |  |             |   |   |                                   | Elizabeth  |                                      |  |   | O'Boyle   |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |             | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   |   |                                   | 17. INFORMANT  |                                      |  | ADDRESS   |   |                                   |
| No  |  |             | 132-16-6426   |   |                                   | John J. Bishop, same as #13  |                                      |  |   |   |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b) and (c))<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a)  |  |             |   |   |                                   |  |                                      |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |                                   |
| Cardio respiratory failure  |  |             |   |   |                                   |  |                                      |  |   |   |                                   |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) Carcinoma of Pancreas   |  |             |   |   |                                   |  |                                      |  |   |   |                                   |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause (b)   |  |             |   |   |                                   |  |                                      |  |   |   |                                   |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |             |   |   |                                   |  |                                      |  |   |   |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a  |  |             |   |   |                                   |  |                                      |  |   |   |                                   |
| 19a. DATE OF OPERATION  |  |             | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |                                   |  |                                      | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  |             | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   |                                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |                                      |  |   |   |                                   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>   |  |             | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |   |                                   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                                      |  |   |   |                                   |
| 22a. I certify that (I) (this hospital) attended the deceased from<br>saw the deceased alive on <u>October 10, 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |             |   |   |                                   |  |                                      |  |   | 22b. DATE SIGNED<br><u>10/12/85</u>   |                                   |
| 22b. SIGNATURE<br><u>Donald Q. Ekman</u>  |  |             | DEGREE<br><u>M.D.</u>   |   |                                   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                      |  |   |   |                                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Donald Q. Ekman, M.D.  |  |             | 22e. ADDRESS<br>4720 Chevy Chase Drive<br>Chevy Chase, Maryland 20815                                     |   |                                   |  |                                      |  |   |   |                                   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  |             | 23b. DATE<br>Oct. 15, 1985  |   |                                   | 23c. NAME OF CEMETERY OR CREMATORIAL<br>Gate of Heaven   |                                      |  | 23d. LOCATION<br>Silver Spring, Maryland                      |   |                                   |
| Burial  |  |             |   |   |                                   |  |                                      |  |   |   |                                   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland 20814   |  |             |   |   |                                   | 25a. DATE REG'D BY REGISTRAR<br>OCT 16 1985  |                                      |  | 25b. REGISTRAR'S SIGNATURE<br><u>Jeanne Dillinger - White</u> |   |                                   |

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100-00100

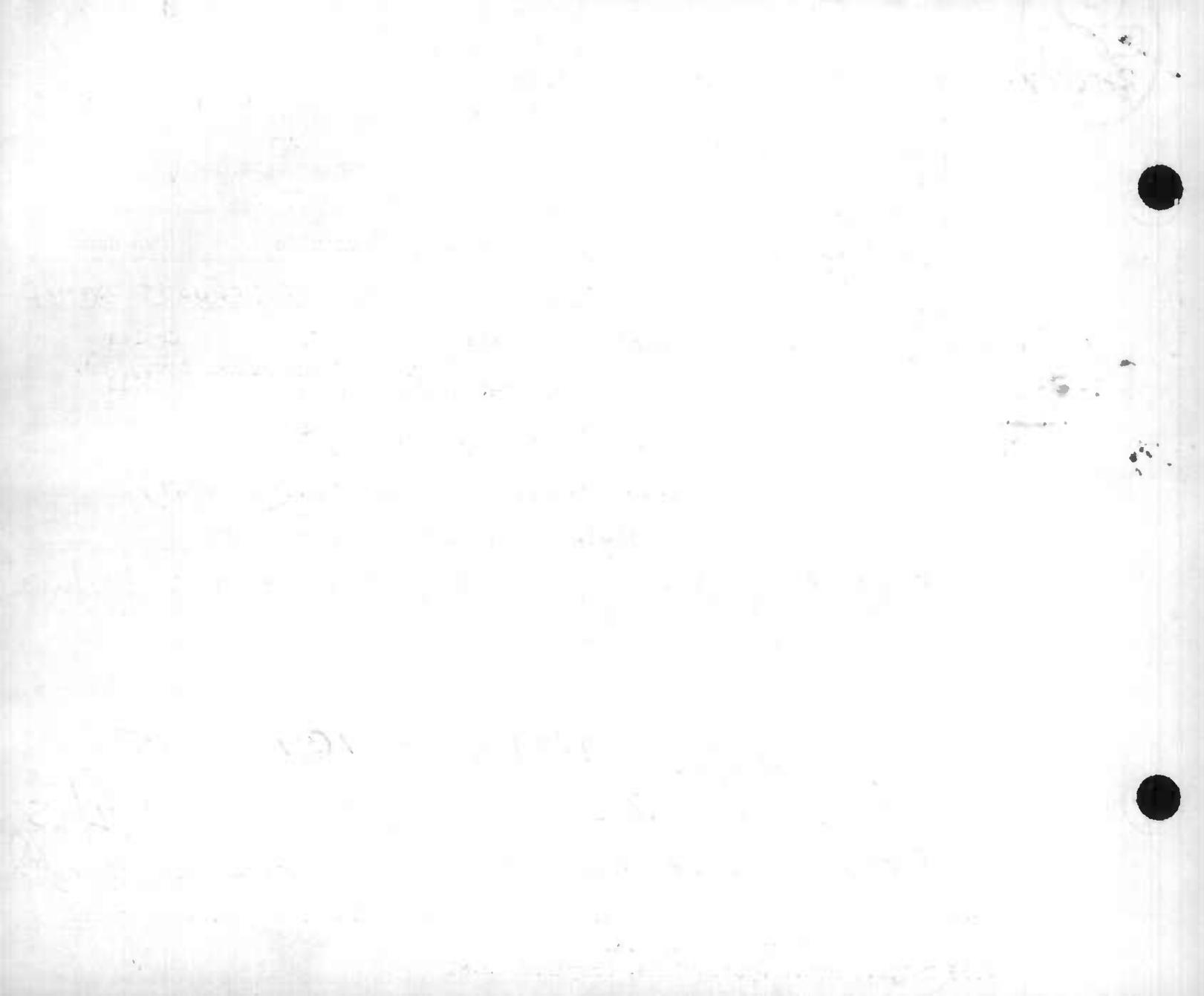
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial transit permit. Then please remove carbonylene from the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked with an X, attach any inquiry, or other narrative, event, or condition which may have contributed to the death.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |               |  |             |   |             |  |                   | 85 28950                             |       |   |      |          |  |
|---|--|---|---------------|--|-------------|---|-------------|--|-------------------|--------------------------------------|-------|---|------|----------|--|
|   |  |   |               |  |             |   |             |  |                   | REG. NO.                             |       |   |      |          |  |
| 1 - FOR<br>STATE<br>REGISTRAR   |  | 1. DECEASED NAME<br>(TYPE OR PRINT)   |               |  | AGNES MOORE |   | BLACK BLACK |  | 2d. DATE OF DEATH |                                      | MONTH | DAY   | YEAR | 2b. HOUR |  |
| 282090  |  | AGNES   |               |  | M           |   | 12-11-1904  |  | 10                |                                      | 1     | 85  |      | 11 53 AM |  |
| FEMALE  |  | 4. RACE   |               | CAUCASIAN  |             | 5. DATE OF BIRTH  |             | 6. AGE (IN YEARS LAST BIRTHDAY)                          |                   | IF UNDER 1 YEAR                      |       | IF UNDER 24 HRS                                 |      |          |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)<br>Missouri   |  | 7b. CITIZEN OF WHAT COUNTRY?  |               | USA  |             | 7c. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                        |             | 80 YRS.  |                   | MONTHS                               |       | DAYS  |      |          |  |
| 10 CITY OR TOWN OF DEATH<br>TAKOMA PARK   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |               | WASHINGTON ADVENTIST HOSP  |             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |             | Housewife  |                   | 12b. KIND OF BUSINESS OR<br>INDUSTRY |       | Own Home  |      |          |  |
| 13a. STATE<br>MD  |  | 13b. COUNTY<br>MONT   |               | 13c. CITY OR TOWN<br>Silver Spring   |             | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |             | 13e. STREET ADDRESS / ZIP CODE<br>3405 CANBERRA ST 20914 |                   |                                      |       |   |      |          |  |
| 14. FATHER'S NAME<br>James  |  | MIDDLE<br>W.  | LAST<br>Moore | 15. MOTHER'S MAIDEN NAME<br>Hattie   |             | J.  | CAPLES      |  |                   |                                      |       |   |      |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.<br>No  |               | 16c. PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)                             |             | 17. INFORMANT<br>13607 Woodedge Drive, Bowie, Md.<br>James D. Black, Son,   |             | ADDRESS  |                   |                                      |       | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |      |          |  |
|   |  | 577-09-3336   |               | respiratory arrest   |             |   |             |  |                   |                                      |       |   |      |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)   |  | DUE TO, OR AS A CONSEQUENCE OF,<br>(b) Aspiration Pneumonia (recurrent)                                   |               | DUE TO, OR AS A CONSEQUENCE OF,<br>(c) Multiple cerebral infarcts                    |             | 18. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I<br>Acute renal Failure Congestive heart failure |             |  |                   |                                      |       |   |      |          |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |               | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |             | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |             |  |                   |                                      |       |   |      |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |               | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |             |   |             |  |                   |                                      |       |   |      |          |  |
| 21d. INJURY OCCURRED<br>AT HOME <input type="checkbox"/> NOT AT HOME <input type="checkbox"/><br>AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |               | 21f. LOCATION<br>STREET  |             | CITY OR TOWN  |             | COUNTY   |                   | STATE                                |       |   |      |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from<br>saw the deceased alive on 20/1/85 19 and that in (my) (our) opinion death occurred on the date and hour and from the cause stated<br>above. (I) (We) (did) (did not) view the body after death. |  | 22b. DEGREE   |               | 22c. ATTENDING<br>PHYSICIAN  |             | 22d. MEDICAL<br>DIRECTOR  |             | 22e. STAFF<br>PHYSICIAN                                  |                   | 22f. DATE SIGNED<br>10/2/85          |       |   |      |          |  |
| 22f. ATTENDING<br>PHYSICIAN<br>Thomas J. Locke, MD  |  | 22g. ADDRESS<br>8580 Second Ave, Silver Spring, Md  |               |  |             |   |             |  |                   |                                      |       |   |      |          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>10-4-85  |               | 23c. NAME OF CEMETERY OR CREMATORIAL<br>Ft. Lincoln Cemetery                         |             | 23d. LOCATION<br>CITY OR TOWN<br>Brentwood, P.G., Maryland  |             |  |                   |                                      |       |   |      |          |  |
| 24. FUNERAL DIRECTOR<br>NAME Francis Gasch's Sons, P.A.<br>ADDRESS<br>4739 Balto., Ave., Hyattsville, Maryland 20781  |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 7 1985   |               | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Rondelle                                |             |   |             |  |                   |                                      |       |   |      |          |  |
| DHMH - 16 50M 4/83<br>(VRA 15, 4)   |  |   |               |  |             |   |             |  |                   |                                      |       |   |      |          |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 may be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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## MEDICAL CERTIFICATION

| 1 - DECEASED NAME   |  |   | FIRST  | MIDDLE  | LAST                     | 2a DATE OF DEATH  | MONTH | DAY  | YEAR  | 2b. HOUR                         |  |
|---|--|---|--------|---|--------------------------|---|-------|--|-------|----------------------------------|--|
| (TYPE OR PRINT)   |  |   | Rae    |   | Blackmon                 | 10  | 6     | 85   | 140 P |                                  |  |
| 3. SEX  |  | 4. RACE   |        | 5. DATE OF BIRTH  |                          | 6. AGE (IN YEARS LAST BIRTHDAY)   |       | 7. IF UNDER 1 YEAR<br>MONTHS DAYS                              |       | 8. IF UNDER 24 HRS<br>HOURS MIN. |  |
| Female  |  | Cauc  |        | Jan. 5, 1894  |                          | 91 92   |       |  |       |                                  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                          | 9. BALTIMORE CITY OR COUNTY OF DEATH  |       |  |       |                                  |  |
| Ohio  |  | U.S.A.  |        |   |                          | Montgomery  |       | MD   |       |                                  |  |
| 10 CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |        | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |                          | 12b. KIND OF BUSINESS OR INDUSTRY   |       |  |       |                                  |  |
| Olney Md  |  | Brooke Grove N. H   |        | Legal Secretary Retired   |                          |   |       |  |       |                                  |  |
| 13a. STATE  |  | 13b. COUNTY   |        | 13c. CITY OR TOWN   |                          | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |       | 13e. STREET ADDRESS / ZIP CODE                                 |       |                                  |  |
| Md.   |  | Montgomery  |        | Olney   |                          | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                             |       | 18430 Brooke Grove Rd. 20832                                   |       |                                  |  |
| 14. FATHER'S NAME   |  | FIRST   | MIDDLE | LAST  | 15. MOTHER'S MAIDEN NAME |   | FIRST | MIDDLE   | LAST  |                                  |  |
| Samuel  |  |   |        | Liebschutz  | Amanda                   |   |       |  | Fox   |                                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.  |        | 17. INFORMANT   |                          | 18. ADDRESS   |       |  |       |                                  |  |
| No  |  | 577-10-9430   |        | D Henry Liebschutz  |                          | 6406 Ruffin Rd.<br>Chevy Chase, Md. 20015   |       |  |       |                                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardio pulmonary arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Congestive heart failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |        |   |                          |   |       |  |       |                                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |        |   |                          |   |       |  |       |                                  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |        |   |                          | 20a. AUTOPSY?   |       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |       |                                  |  |
| 19c. YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |        |   |                          | YES <input type="checkbox"/> NO <input type="checkbox"/>  |       | YES <input type="checkbox"/> NO <input type="checkbox"/>       |       |                                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |                          |   |       |  |       |                                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |        | 21f. LOCATION<br>STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____   |                          |   |       |  |       |                                  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/1/77</u> to <u>10/6/85</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |        |   |                          |   |       |  |       |                                  |  |
| 22b. SIGNATURE<br><u>Kwang S. Kim</u>   |  | DEGREE<br><u>M.D.</u>   |        | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |                          | 22c. DATE SIGNED<br><u>10/6/85</u>  |       |  |       |                                  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Kwang S. Kim</u>  |  | 22e. ADDRESS<br><u>50 W. Edmonston Dr. Rockville MD. 20852</u>  |        |   |                          |   |       |  |       |                                  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation   |  | 23b. DATE<br>10/6/85  |        | 23c. NAME OF CEMETERY OR CREMATORIAL<br>Lee's Crematory   |                          | 23d. LOCATION<br>Washington D.C.  |       |  |       |                                  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Columbia Mortuary Services Inc.<br>225 Missouri Ave. N.W. Wash. D.C.  |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 9 1985   |        | 25b. REGISTRAR'S SIGNATURE<br><u>Jeanne Devine</u>  |                          |   |       |  |       |                                  |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |   |                                    |  |  |                                     |                 |   |                 |      |  |
|--|--|--|---|------------------------------------|--|--|-------------------------------------|-----------------|---|-----------------|------|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)   |  |  | FIRST   | MIDDLE                             | LAST   | 2a DATE OF DEATH   | MONTH                               | DAY             | YEAR  | 2b HOUR         |      |  |
| EVA M. Blankschip  |  |  |   |                                    |  | 10/11/85   |                                     |                 |   | 0052 AM         |      |  |
| 3. SEX   |  |  | 4. RACE   | 5. DATE OF BIRTH<br>MONTH DAY YEAR |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |                                     | IF UNDER 1 YEAR |   | IF UNDER 24 HRS |      |  |
| FEMALE   |  |  | WHITE   | MARCH 3, 1909                      |  | 76   |                                     | MONTHS          | DAYS  | HOURS           | MIN. |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)   |  |  | 7b. CITIZEN OF WHAT COUNTRY?  |                                    | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH |                 |   |                 | MD.  |  |
| W. Va.   |  |  | U.S.A.  |                                    |  |  | Montgomery                          |                 |   |                 |      |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                    |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |                                     |                 | 12b. KIND OF BUSINESS OR INDUSTRY   |                 |      |  |
| Takoma Park  |  |  | WASH. ADVENTURE Hospital  |                                    |  | CLERK  |                                     |                 | PEOPLES DRUGSTORE   |                 |      |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  | 13a. STATE  |                                    |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                                     |                 | 13e. STREET ADDRESS / ZIP CODE  |                 |      |  |
| MARYLAND   |  |  | 13b. COUNTY   |                                    |  | 13c. CITY OR TOWN  |                                     |                 | 1004 FAIRVIEW AVE 20912   |                 |      |  |
| Mont.  |  |  | Takoma Park   |                                    |  |  |                                     |                 |   |                 |      |  |
| 14. FATHER'S NAME  |  |  | FIRST   | MIDDLE                             | LAST   | 15. MOTHER'S MAIDEN NAME   |                                     |                 | LAST  |                 |      |  |
| JAMES  |  |  |   |                                    | HIGGENBOTHAM   | MARTHA   |                                     |                 | 2/13  |                 |      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |  | 16b. SOCIAL SECURITY NO.  |                                    |  | 17. INFORMANT  |                                     |                 | 3601 VAN NESS ST. NW<br>WASIT. D.C.   |                 |      |  |
| No   |  |  | 236-24-8033A  |                                    |  | Anita Kuzio  |                                     |                 |   |                 |      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a)                        |  |  | INSULIN Dependent Diabetes mellitus   |                                    |  |  |                                     |                 |   |                 |      |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |   |                                    |  |  |                                     |                 |   |                 |      |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |   |                                    |  |  |                                     |                 |   |                 |      |  |
| (b)  |  |  |   |                                    |  |  |                                     |                 |   |                 |      |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |   |                                    |  |  |                                     |                 |   |                 |      |  |
| (c)  |  |  |   |                                    |  |  |                                     |                 |   |                 |      |  |
| APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH  |  |  |   |                                    |  |  |                                     |                 |   |                 |      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a                       |  |  |   |                                    |  |  |                                     |                 |   |                 |      |  |
| COPD, CHF, ASHD, Hypertension  |  |  |   |                                    |  |  |                                     |                 |   |                 |      |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                    |  | 20a. AUTOPSY?  |                                     |                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                 |      |  |
|  |  |  |   |                                    |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                     |                 | YES <input type="checkbox"/> NO <input type="checkbox"/>  |                 |      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |                                     |                 |   |                 |      |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>                          |  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)                                     |                                    |  | 21f. LOCATION<br>STREET  |                                     |                 | CITY OR TOWN COUNTY STATE   |                 |      |  |
| 22a. I certify that (I) (this hospital) attended the deceased from<br>saw the deceased alive above (I) (we) (did) (did not) view the body after death. |  |  | 10-10 1985  |                                    |  | 19-80 to 10-11 1985  |                                     |                 | that (I) (we) lost  |                 |      |  |
| 22b. SIGNATURE   |  |  | DEGREE  |                                    |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                     |                 | 22c. DATE SIGNED  |                 |      |  |
| Lee S. De  |  |  | MS  |                                    |  |  |                                     |                 | 10-11-85  |                 |      |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  | 22e. ADDRESS  |                                    |  |  |                                     |                 |   |                 |      |  |
| 23a. BURIAL, CREMATION, REMOVAL  |  |  | 23b. DATE   |                                    |  | 23c. NAME OF CEMETERY OR CREMATORIAL   |                                     |                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |                 |      |  |
| Burial   |  |  | 10-14-85  |                                    |  | Mt. Lincoln Cem.   |                                     |                 | Washington, D.C.  |                 |      |  |
| 24. FUNERAL DIRECTOR<br>NAME   |  |  | DEVOL Federal Home  |                                    |  | 23e. DATE REC'D. BY REGISTRAR  |                                     |                 | 23f. REGISTRAR'S SIGNATURE  |                 |      |  |
| John E. Egan   |  |  |   |                                    |  | OCT 18 1985  |                                     |                 |   |                 |      |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attorney (if any) and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove the top portion of pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or cremantsion.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the midwife, summer and the authoriz-

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 4 may be continued by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it may be used as the burial-trust permit. Then please remove carbon copies. Panel 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the deceased. If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |        |  |  |   |   |                              | 85 28953   |       |   |         |  |
|---|--|--|--|--------|--|--|---|---|------------------------------|--|-------|---|---------|--|
|   |  |  |  |        |  |  |   |   |                              | REG. NO.   |       |   |         |  |
| 1 - FOR<br>STATE<br>REGISTRAR   |  |  | 2a DATE OF DEATH MONTH DAY YEAR  |        |  |  |   |   |                              | 2b HOUR  |       |   |         |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  | FIRST  | MIDDLE | LAST   | OCTOBER 17, 1985   |   |   |                              |  |       |   | 7:00P M |  |
| STEPHEN EDWARD BLASER   |  |  |  |        |  |  |   |   |                              |  |       |   |         |  |
| 3 SEX   |  |  | 4 RACE   |        | 5. DATE OF BIRTH<br>MONTH DAY YEAR   |  |   | 6. AGE (IN YEARS LAST BIRTHDAY)                               |                              |  |       | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                 |         |  |
| MALE  |  |  | WHITE  |        | NOVEMBER 10, 1960  |  |   | 24 YRS.   |                              |  |       |   |         |  |
| 7a BIRTHPLACE<br>COUNTRY<br>ILLINOIS  |  |  | 7b CITIZEN OF WHAT COUNTRY?<br>USA   |        | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY COUNTY MD. |                              |  |       |   |         |  |
| 10 CITY OR TOWN OF DEATH<br>BETHESDA  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE CLINICAL CENTER |        | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Mechanic-Paper and plastic  |  |   | 12b KIND OF BUSINESS OR<br>INDUSTRY<br>999999 60436           |                              |  |       |   |         |  |
| 13a STATE<br>ILLINOIS   |  |  | 13b COUNTY<br>Will   |        | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   | 13e STREET ADDRESS / ZIP CODE<br>131 TURTLE ST.               |                              |  |       |   |         |  |
| 14 FATHER'S NAME<br>William O. Blaser   |  |  |  |        | 15 MOTHER'S MAIDEN NAME<br>L. Arlene Holt  |  |   |   |                              |  |       |   |         |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No  |  |  | 16b SOCIAL SECURITY NO.<br>N/A   |        | 17 INFORMANT<br>MRS. LILLY BLASER  |  |   | ADDRESS<br>SAME AS ABOVE (MOTHER)                             |                              |  |       |   |         |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a))   |  |  |  |        | RESPIRATORY FAILURE  |  |   |   |                              |  |       | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>1 WEEK |         |  |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause, if any.  |  |  | (b) METASTATIC MELANOMA TREATED WITH IMMUNOTHERAPY   |        |  |  |   |   |                              |  |       |   |         |  |
|   |  |  | (c)  |        |  |  |   |   |                              |  |       |   |         |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |        |  |  |   |   |                              |  |       |   |         |  |
| 19a DATE OF OPERATION   |  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |        |  |  |   | 20a AUTOPSY?  |                              | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |       |   |         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |   |                              |  |       |   |         |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |        | 21f. LOCATION<br>STREET  |  |   | CITY OR TOWN  |                              | COUNTY   | STATE |   |         |  |
| 22a. I certify that (I) (this hospital) intended the deceased from October 5, 1985, to October 17, 1985, that <input checked="" type="checkbox"/> (we) lost<br>saw the deceased alive on October 17, 1985, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated<br>above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (not) view the body after death. |  |  |  |        |  |  |   |   |                              |  |       |   |         |  |
| 22b. SIGNATURE<br><i>Male B. Pape</i>   |  |  | DEGREE   |        |  | ATTENDING<br>PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF<br>PHYSICIAN <input checked="" type="checkbox"/> |   |   | 22c. DATE SIGNED<br>10/19/85 |  |       |   |         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Male B. Pape M.D.  |  |  | 22e. ADDRESS NATIONAL INSTITUTES OF HEALTH<br>CLINICAL CENTER, BETHESDA, MARYLAND 20892  |        |  |  |   |   |                              |  |       |   |         |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>Burial   |  |  | 23b. DATE<br>10-22-85  |        | 23c. NAME OF CEMETERY OR CREMATORIAL<br>Woodlawn Memorial Pk.  |  |   | 23d. LOCATION<br>CITY STATE<br>Joliet, Ill.                   |                              | COUNTY   |       |   |         |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>Ives-Pearson Funeral Homes<br>Arlington, Va. 22201   |  |  | 25a. DATE RECEIVED BY REGISTRAR<br>Oct 28 1985   |        |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>G. K. Anderson, R.P.D.</i> |   |                              |  |       |   |         |  |

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 28954

REG. NO.

|  |  |   |       |   |              |  |           |   |                |                        |  |
|--|--|---|-------|---|--------------|--|-----------|---|----------------|------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   | FIRST | MIDDLE  | LAST         | 2a. DATE OF DEATH  | MONTH     | DAY   | YEAR           | 2b. HOUR               |  |
| <i>Madeline C. Bolin</i>   |  |   |       |   | <i>Bolin</i> | <i>10</i>  | <i>01</i> | <i>85</i>   | <i>10248 M</i> |                        |  |
| 3. SEX   |  | 4. RACE   |       | 5. DATE OF BIRTH  |              | 6. AGE (IN YEARS LAST BIRTHDAY)  |           | 7. IF UNDER 1 YEAR  |                | 8. IF UNDER 1 HRS      |  |
| <i>Female</i>  |  | <i>Black</i>  |       | <i>FEB. 4, 1933</i>   |              | <i>52</i>  |           | YRS   |                | MONTHS DAYS HOURS MIN. |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |       | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |              | 9. BALTIMORE CITY OR COUNTY OF DEATH   |           | MD.   |                |                        |  |
| <i>MD</i>  |  | <i>U.S.A.</i>   |       |   |              | <i>Mary</i>  |           | <i>Mary</i>   |                |                        |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |       | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |              | 12b. KIND OF BUSINESS OR<br>INDUSTRY   |           |   |                |                        |  |
| <i>Silver Spring</i>   |  | <i>Holy Cross Hospital</i>  |       | <i>Bus Driver</i>   |              | <i>Ed. of Ed.</i>  |           |   |                |                        |  |
| 13a. STATE   |  | 13b. COUNTY   |       | 13c. CITY OR TOWN   |              | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |           | 13e. STREET ADDRESS / ZIP CODE  |                |                        |  |
| <i>Md.</i>   |  | <i>Montgomery</i>   |       | <i>Silver Spring</i>  |              | <i>YES</i>   |           | <i>2720 Norbeck Rd / 20906</i>  |                |                        |  |
| 14. FATHER'S NAME<br>FIRST   |  | MIDDLE  |       | LAST  |              | 15. MOTHER'S MAIDEN NAME<br>FIRST  |           | MIDDLE  |                | LAST                   |  |
| <i>Joseph</i>  |  | <i>M.</i>   |       | <i>Lee</i>  |              | <i>Alice E. Sedgwick</i>   |           |   |                |                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   |       | 17. INFORMANT   |              | 18. APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH  |           |   |                |                        |  |
| <i>No</i>  |  | <i>579-46-9825</i>  |       | <i>Paul Lee, Se(Bro.)</i>   |              | <i>weeks</i>   |           | <i>4239 Muncaster Mill Rd.<br/>Rockville, Md.</i>   |                |                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) _____   |  |   |       |   |              | RESPIRATORY FAILURE  |           |   |                |                        |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause (b).<br><br>(b) _____  |  |   |       |   |              | DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |           |   |                |                        |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a<br><i>CHRONIC RENAL FAILURE, SYSTEMIC LUPUS ERYTHEMATOSIS</i>  |  |   |       |   |              |  |           |   |                |                        |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |       |   |              | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |           | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                |                        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |              |  |           |   |                |                        |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |       | 21f. LOCATION<br>STREET   |              | CITY OR TOWN   |           | COUNTY  |                | STATE                  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <i>September 2, 1985</i> to <i>October 1, 1985</i> , that (I) (we) last<br>saw the deceased alive on <i>September 30, 1985</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |       |   |              |  |           |   |                |                        |  |
| 22b. SIGNATURE<br><i>Barney Hecht, M.D.</i>  |  | DEGREE  |       |   |              | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |           | 22c. DATE SIGNED<br><i>October 1, 1985</i>  |                |                        |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Barney Hecht</i>   |  | 22e. ADDRESS<br><i>3121 Ferrara Drive Wheaton MD 20906</i>  |       |   |              |  |           |   |                |                        |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>TYPE  |  | 23b. DATE<br><i>10-5-85</i>   |       | 23c. NAME OF CEMETERY OR CREMATORIUM<br><i>Gate of Heaven Cem. Silver Spring</i>  |              | 23d. LOCATION<br>CITY OR TOWN<br><i>Silver Spring</i>  |           | COUNTY  |                | STATE                  |  |
| 24. FUNERAL DIRECTOR<br>NAME   |  | ADDRESS<br><i>246 N. WASH. ST.</i>  |       | 25a. DATE REC'D. BY REGISTRAR<br><i>OCT 04 1985</i>   |              | 25b. REGISTRAR'S SIGNATURE<br><i>Juliann Pendall</i>   |           |   |                |                        |  |
| BP _____   |  |   |       |   |              |  |           |   |                |                        |  |
| DHMH - 16 60M 7/84<br>(VRA 15, 4)  |  |   |       |   |              |  |           |   |                |                        |  |

161825



294096

85 28455

**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH**

REG. NO.

1 -  
FOR  
STATE  
REGISTRAR

|   |  |  |        |   |                          |   |       |  |          |                              |  |                                |  |
|---|--|--|--------|---|--------------------------|---|-------|--|----------|------------------------------|--|--------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  | FIRST  | MIDDLE  | LAST                     | 2a. DATE OF DEATH   | MONTH | DAY  | YEAR     | 2b. HOUR                     |  |                                |  |
| Thomas F. Bomango   |  |  |        |   |                          | 10-4-85   |       |  |          | 8:49A.M.                     |  |                                |  |
| 3. SEX  |  | 4. RACE  |        | 5. DATE OF BIRTH  |                          | 6. AGE (IN YEARS LAST BIRTHDAY)   |       | IF UNDER 1 YEAR  |          | IF UNDER 24 HRS.             |  |                                |  |
| Male  |  | White  |        | MONTH DAY YEAR  |                          | 57  |       | YEARS  | MONTHS   | DAYS                         | HOURS MIN.                             |                                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |        | 8. MARRIED  |                          | NEVER MARRIED   |       | <input checked="" type="checkbox"/>                            |          |                              |  |                                |  |
| New York  |  | U.S.A.   |        | <input checked="" type="checkbox"/>   |                          | WIDOWED   |       | <input type="checkbox"/>                                       |          | DIVORCED                     |  | <input type="checkbox"/>       |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |        | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |                          | 12b. KIND OF BUSINESS OR INDUSTRY   |       | MD.  |          |                              |  |                                |  |
| Clarksburg  |  | 24520 Frederick Rd.  |        | Hairdresser   |                          | Owner/operator  |       |  |          |                              |  |                                |  |
| 13a. STATE  |  |  |        |   |                          | 13b. COUNTY   |       | 13c. CITY OR TOWN  |          | 13d. INSIDE CITY LIMITS?     |  | 13e. STREET ADDRESS / ZIP CODE |  |
| Maryland  |  |  |        |   |                          | Montgomery  |       | Clarksburg   |          | YES <input type="checkbox"/> | NO <input checked="" type="checkbox"/> | Clarksburg, Md. 20871          |  |
| 14. FATHER'S NAME   |  | FIRST  | MIDDLE | LAST  | 15. MOTHER'S MAIDEN NAME |   | FIRST | MIDDLE   | LAST     |                              |  |                                |  |
| Anthony   |  |  |        | Bomango   | Mary                     |   |       |  | Lavaglio |                              |  |                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | (IF YES, GIVE WAR OR DATES)  |        | 17. INFORMANT   |                          | ADDRESS   |       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |          |                              |  |                                |  |
| Yes   |  | WWII   |        | UNKNOWN   |                          | Nancy Bomango 101W. Patrick St. Fred.   |       |  |          |                              |  | months                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)  |  |  |        |   |                          | Arrhythmia  |       |  |          |                              |  |                                |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |        |   |                          | DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic cardiovascular disease 3 years |       |  |          |                              |  |                                |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |        |   |                          |   |       |  |          |                              |  |                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (d)   |  |  |        |   |                          |   |       |  |          |                              |  |                                |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |        |   |                          | 20a. AUTOPSY?   |       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |          |                              |  |                                |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY  |        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2) |                          | YES <input type="checkbox"/> NO <input type="checkbox"/>                          |       | YES <input type="checkbox"/> NO <input type="checkbox"/>       |          |                              |  |                                |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)                                     |        | 21f. LOCATION   |                          | STREET  |       | CITY OR TOWN   | COUNTY   | STATE                        |  |                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did/did not view the body after death. |  |  |        |   |                          |   |       |  |          |                              |  |                                |  |
| 22b. SIGNATURE DEGREE   |  |  |        |   |                          |   |       |  |          |                              |  |                                |  |
| 22c. DATE SIGNED 10-7-85  |  |  |        |   |                          |   |       |  |          |                              |  |                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |        |   |                          |   |       |  |          |                              |  |                                |  |
| Dr. Lewis Lipson  |  | 5530 Wisconsin Ave. Chevy Chase Md.  |        |   |                          |   |       |  |          |                              |  |                                |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |        | 23c. NAME OF CEMETERY OR CREMATORIAL  |                          | 23d. LOCATION   |       |  |          |                              |  |                                |  |
| Burial  |  | 10-7-85  |        | Resthaven Mem. Gds.   |                          | Frederick Fred. Md.   |       |  |          |                              |  |                                |  |
| 24. FUNERAL DIRECTOR  |  | NAME   |        | ADDRESS   |                          | DATE REC'D BY REGISTRAR   |       | REGISTRAR'S SIGNATURE  |          |                              |  |                                |  |
|   |  | G. Douglas Stauffer  |        |   |                          | OCT 14 1985   |       | John L. Johnson, Jr.   |          |                              |  |                                |  |
|   |  | 1621 Opossumtown Pike, Fred. Md. 21701   |        |   |                          |   |       |  |          |                              |  |                                |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove carbon paper and send to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner

aeolies



1. *Stamps and Inval.* 300 p. 1. 700

294002

85 28 950

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - STATE REGISTRAR

|  |  |   |                |   |              |   |              |  |              |                               |  |
|--|--|---|----------------|---|--------------|---|--------------|--|--------------|-------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   | FIRST<br>Helen | MIDDLE<br>B.  | LAST<br>Bond | 2a. DATE OF DEATH<br>October 15 1985  | MONTH<br>OCT | DAY<br>15  | YEAR<br>1985 | 2b. HOUR<br>1:15AM            |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Caucasian</b>   |                | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>September 22, 1892</b>   |              | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>93</b><br>YRS   |              | IF UNDER 1 YEAR<br>MONTHS DAYS   |              | IF UNDER 24 HRS<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>  |                | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |              | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County, MD.</b>                           |              |  |              |                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rockville</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Potomac Valley Nursing Home</b> |                | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>  |              | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>  |              |  |              |                               |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Montgomery</b>  |                | 13c. CITY OR TOWN<br><b>Silver Spring</b>   |              | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |              | 13e. STREET ADDRESS / ZIP CODE<br><b>15143 Vantage Hill Road / 20906</b> |              |                               |  |
| 14. FATHER'S NAME<br>FIRST<br><b>Henry</b>   |  | MIDDLE<br><b>R.</b>   |                | LAST<br><b>Byrd</b>   |              | 15. MOTHER'S MAIDEN NAME<br>FIRST<br><b>Pearl</b>   |              | MIDDLE   |              | LAST<br><b>Young</b>          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES OR NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   |                | 17. INFORMANT   |              | ADDRESS   |              | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>4 weeks</b>        |              |                               |  |
| <b>No</b>  |  | <b>578-03-1562</b>  |                | <b>Mrs. Mervale B. Russell, Daughter, Same as #13</b>   |              |   |              |  |              |                               |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>ASystole</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Arteriosclerotic Heart Disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) _____  |  |   |                |   |              |   |              |  |              |                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |                |   |              |   |              |  |              |                               |  |
| 19a. MEDICAL CERTIFICATION   |  | 19b. DATE OF OPERATION  |                | 19c. CONDITION FOR WHICH OPERATION WAS PERFORMED  |              | 19d. AUTOPSY?   |              | 19e. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?           |              |                               |  |
|  |  |   |                |   |              | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                             |              | YES <input type="checkbox"/> NO <input type="checkbox"/>                 |              |                               |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21a. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                | 21b. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 20, PART 1 OR PART 2)  |              |   |              |  |              |                               |  |
| 21a. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21b. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                | 21c. LOCATION<br>STREET   |              | CITY OR TOWN  |              | COUNTY   |              | STATE                         |  |
| 22a. I certify that (I, the physician) attended the deceased from <b>1985</b> to <b>1985</b> , that (I) <input type="checkbox"/> last saw the deceased alive on <b>1985</b> , and that in my ( <b>attending physician</b> ) opinion death occurred on the date and hour and from the causes stated in Part II (weird). (I) <input type="checkbox"/> may now know the cause of death. |  |   |                |   |              |   |              |  |              |                               |  |
| 23a. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Thomas E. Dooley, MD</b>   |  | 23b. DEGREE<br><b>MD</b>  |                | 23c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>             |              | 23d. DATE SIGNED<br><b>10/18/85</b>   |              |  |              |                               |  |
| 23e. ADDRESS<br><b>17904 Georgia Av., Olney, Maryland 20832</b>  |  |   |                |   |              |   |              |  |              |                               |  |
| 23f. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23g. DATE<br><b>19 October 1985</b>   |                | 23h. NAME OF CEMETERY OR CREMATORIAL<br><b>Rock Creek Cemetery</b>  |              | 23i. LOCATION<br>CITY OR TOWN<br><b>Washington, D.C.</b>  |              |  |              |                               |  |
| 24. FUNERAL DIRECTOR <b>Robert A. Pumphrey Funeral Homes, P.A., 300 West Montgomery, Rockville, MD. 20850</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 18 1985</b>   |                | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Dooley Dooley</b>  |              |   |              |  |              |                               |  |

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that this certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial transit permit. Then please send carbon copies of pages 1 and 2 to the State Dept. of Health and Mental Hygiene prior to burial or removal.

ITEM 21. If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be recovered, within 48 hours, by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completed, it should be retained for use as the burial-trust permit. Then please remove carbon duplicate. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and the medical certificate must be signed by the physician.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |  |  | REG. NO. 85 28 95 /  |  |
|--|--|--|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>JOSEPH W. BORTNICK</b>   |  |  | 2a. DATE OF DEATH<br><b>Oct. 8, 1985</b>          | MONTH<br>DAY<br>YEAR   | 2b. HOUR<br><b>10:10 p.m.</b>  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH<br><b>Aug. 19, 1916</b> | DAY  | YEAR   |  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)<br><b>Wash., D.C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. AGE (IN YEARS LAST BIRTHDAY)<br><b>69 yrs</b>  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rockville</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>11400 Strand Drive</b> |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b>                            |  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Montgomery</b>   |   | 13c. CITY OR TOWN<br><b>Rockville</b>  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Owner (Ret.)</b>  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br><b>Trucking Ind.</b> |
| 14. FATHER'S NAME<br>FIRST<br><b>Alexander</b>   |  | MIDDLE<br><b>Bortnick</b>  | LAST<br><b>Ida</b>                                | 15. MOTHER'S MAIDEN NAME<br>FIRST<br><b>Scheer</b>                             |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>579/18/0279</b>   |   | 17. INFORMANT<br><b>Millicent Bortnick; 11400 Strand Drive</b>                 |  | 18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Disseminated Carcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Adenocarcinoma of Colon</b><br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause lost.<br>(c)<br>DUE TO, OR AS A CONSEQUENCE OF<br>2 years |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.   |  |  |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 21a. ACCIDENT WAS UNDERLYING<br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET  | CITY OR TOWN   | COUNTY   | STATE  |
| 22a. I certify that (I) this hospital attended the deceased from <b>10/3, 1985</b> , to <b>10/7, 1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |   |  |  |  |  |
| 22b. SIGNATURE<br><b>G. Lennard Gold</b>   |  | 22c. DEGREE<br><b>MD</b>   |   | 22d. DATE SIGNED<br><b>10-9-1985</b>   |  |  |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>G. Lennard Gold</b>  |  | 22f. ADDRESS<br><b>8630 Fenton St. Silver Spring, Md.</b>  |   | 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                  |  |  |  |
| 23b. DATE<br><b>Oct. 10, 1985</b>  |  | 23c. NAME OF CEMETERY OR CREMATORIAL<br><b>B'nai Israel Cem.</b>   |   | 23d. LOCATION<br>CITY OR TOWN<br><b>Oxon Hill, Maryland</b>                    |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Danzansky-Goldberg Chapels; 1170 Rockville Pike</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 15 1985</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Jeanne Danzansky Goldberg</b>                 |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use of the burial-transit permit. Then please remove carbon papers. Please do not file this certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner may be

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |   |      |   |  |                        |  |         |  |  |   |  |  |
|--|--|---|--|---|---|------|---|--|------------------------|--|---------|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   |  | FIRST   | MIDDLE  | LAST | 2a DATE OF DEATH  | MONTH  | DAY                    | YEAR   | 2b HOUR |  |  |   |  |  |
| MARGARET   |  |   |  | M.  |   | BOYD | OCTOBER   | 2,   | 1985                   | P  |         |  |  |   |  |  |
| 2. SEX   |  | 3. RACE   |  | 4. DATE OF BIRTH  |   |      | 5. AGE (IN YEARS LAST BIRTHDAY)   |  |                        | 6. IF UNDER 18 YEARS   |         |  |  |   |  |  |
| FEMALE   |  | CAUCASIAN   |  | FEB 16, 1920  |   |      | 65  |  |                        | MONTHS   | YEARS   |  |  |   |  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   |      | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |                        | 10. CITY OR TOWN OF DEATH  |         |  |  |   |  |  |
| PENNSVANIA   |  | U.S.A.  |  |   |   |      | MONTGOMERY  |  |                        | ROCKVILLE  |         |  |  |   |  |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  |  |   |  |   |   |      |   |  |                        |  |         | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |
| 6717 HEATHERFORD COURT   |  |   |  |   |   |      |   |  |                        |  |         | HOUSEWIFE  |  | 6717 HEATHERFORD COURT 20855  |  |  |
| 13a. STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |   |      | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                        | 13e. STREET ADDRESS / ZIP CODE   |         |  |  |   |  |  |
| MARYLAND   |  | MONTGOMERY  |  | ROCKVILLE   |   |      |   |  |                        | 6717 HEATHERFORD COURT   |         |  |  |   |  |  |
| 14. FATHER'S NAME<br>FIRST   |  | MIDDLE  |  | LAST  |   |      | 15. MOTHER'S MAIDEN NAME<br>FIRST   |  |                        | MIDDLE   |         | LAST   |  |   |  |  |
| CARL   |  |   |  | FASSBACH  |   |      | ALICE   |  |                        |  |         | MICHAEL  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | (IF YES, GIVE WAR OR DATES)   |  | 16b. SOCIAL SECURITY NO.  |   |      | 17. INFORMANT   |  |                        | ADDRESS  |         | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) |  |   |  |  |
| NO   |  |   |  | 577-09-9639   |   |      | HOWARD J. BOYD  |  |                        | SAME AS 13   |         | SON  |  | Metastatic carcinoma of the lung<br>APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>1 year |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause, if any.<br>(b)  |  |   |  |   |   |      |   |  |                        |  |         |  |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |   |  |   |   |      |   |  |                        |  |         |  |  |   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |  |   |   |      |   |  |                        |  |         |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                      |  |   |   |      |   | 20a. AUTOPSY?                                |                        | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |         |  |  |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19            |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2) |      |   |  |                        |  |         |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM ETC.) |  |   | 21f. LOCATION<br>STREET   |      |   | CITY OR TOWN                                 |                        | COUNTY   | STATE   |  |  |   |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from August 19, 1982, to Oct. 2, 1983, that (1) (we) lost<br>saw the deceased alive on Sept. 20, 1985, and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above. (1) (we) did not view the body after death. |  |   |  |   |   |      |   |  |                        |  |         |  |  |   |  |  |
| 22b. SIGNATURE<br>William H. Silverman   |  | 22c. DEGREE<br>MD   |  |   | 22d. ATTENDING<br>PHYSICIAN <input checked="" type="checkbox"/>               |      |   | MEDICAL<br>DIRECTOR <input type="checkbox"/> |                        | STAFF<br>PHYSICIAN <input type="checkbox"/>  |         | 22e. DATE SIGNED<br>10/2/85  |  |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>WILLIAM H. SILVERMAN, MD  |  | 22e. ADDRESS<br>6111 EXECUTIVE BLVD, ROCKVILLE, MD                    |  |   |   |      |   |  |                        |  |         |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 23b. DATE<br>BURIAL 10/5/85   |  | 23c. NAME OF CEMETERY OR CREMATORIAL<br>GEORGE WASHINGTON   |   |      | 23d. LOCATION<br>CITY OR TOWN<br>ADEPHI   |  | CITY OR TOWN<br>ADEPHI |  | COUNTY  | STATE  |  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME   |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 9 1985                           |  |   | 25b. REGISTRAR'S SIGNATURE<br>Julie Carlson Pendleton                         |      |   |  |                        |  |         |  |  |   |  |  |
| FRANCIS J. COLLINS<br>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901  |  |   |  |   |   |      |   |  |                        |  |         |  |  |   |  |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

1 - FOR  
STATE  
REGISTRAR

|   |  |   |        |   |                             |  |  |                                     |           |   |      |
|---|--|---|--------|---|-----------------------------|--|--|-------------------------------------|-----------|---|------|
| 1 DECEASED NAME<br>(TYPE OR PRINT)  |  |   | FIRST  | MIDDLE  | LAST                        | 2a DATE OF DEATH   | MONTH                                  | DAY                                 | YEAR      | 2b HOUR   |      |
| Robert  |  |   | W.     |   | Bradley                     | 10   | 14                                     | 85                                  | 4:27 A.M. |   |      |
| 3 SEX   |  | 4 RACE  |        | 5. DATE OF BIRTH  |                             | 6 AGE (IN YEARS LAST BIRTHDAY)   |  | IF UNDER 1 YEAR                     |           | IF UNDER 24 HRS                                 |      |
| Male  |  | Caucasian   |        | MONTH   | DAY                         | YEAR   | 73                                     | MONTHS                              | YEARS     | MONTHS  | DAYS |
| 7a BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)  |  | 7b CITIZEN OF WHAT COUNTRY?   |        | 8   |                             | MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH |           | MD.   |      |
| Oklahoma  |  | United States   |        |   |                             |  |  | Montgomery County                   |           |   |      |
| 10 CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |        | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |                             | 12b. KIND OF BUSINESS OR<br>INDUSTRY   |  |                                     |           |   |      |
| Bethesda  |  | Suburban Hospital   |        | Analyst   |                             | U.S. Government  |  |                                     |           |   |      |
| 13 STATE  |  | 13b COUNTY  |        | 13c CITY OR TOWN  |                             | 13d INSIDE CITY LIMITS?  |  | 13e STREET ADDRESS / ZIP CODE       |           |   |      |
| Maryland  |  | Montgomery  |        | Bethesda  |                             | YES <input type="checkbox"/>   | NO <input checked="" type="checkbox"/> | 7113 Braeburn Place/ 20817          |           |   |      |
| 14 FATHER'S NAME  |  | FIRST   | MIDDLE | LAST  | 15 MOTHER'S MAIDEN NAME     |  | FIRST                                  | MIDDLE                              | LAST      |   |      |
|   |  | Robert  | W.     | Bradley   |                             |  | Lottie                                 | Lea                                 | Wallace   |   |      |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b SOCIAL SECURITY NO.   |        | 17 INFORMANT  |                             | ADDRESS  |  |                                     |           |   |      |
| Yes   |  | WW II   |        | 446 01 9108   |                             | Zoe H. Bradley-wife- see #13   |  |                                     |           |   |      |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a))   |  |   |        |   |                             |  |  |                                     |           | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |      |
| Retroperitoneal Hemorrhage  |  |   |        |   |                             |  |  |                                     |           | 1 week  |      |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) Hemorrhage - Empyema Gallbladder  |  |   |        |   |                             |  |  |                                     |           | 2 months  |      |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |   |        |   |                             |  |  |                                     |           |   |      |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |        |   |                             |  |  |                                     |           |   |      |
| Liver Disease : Kidney Stones; Gastrointestinal Hemorrhage  |  |   |        |   |                             |  |  |                                     |           |   |      |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |        | 20a AUTOPSY?  |                             | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?  |  |                                     |           |   |      |
|   |  |   |        | YES <input checked="" type="checkbox"/>   | NO <input type="checkbox"/> | YES <input checked="" type="checkbox"/>  | NO <input type="checkbox"/>            |                                     |           |   |      |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |        | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |                             |  |  |                                     |           |   |      |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |        | 21f. LOCATION<br>STREET   |                             | CITY OR TOWN   | COUNTY                                 | STATE                               |           |   |      |
| 22a I certify that (I) <input type="checkbox"/> attended the deceased from 10-7, 1985, to 10-13, 1985, that (I) <input type="checkbox"/> lost<br>saw the deceased alive on 10-13 1985, and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated<br>above. (I) <input type="checkbox"/> did not view the body after death. |  |   |        |   |                             |  |  |                                     |           | 22c. DATE SIGNED                                |      |
| 22b SIGNATURE<br>Alan N. Schulman, MD   |  |   |        |   |                             |  |  |                                     |           | 10/15/85  |      |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e ADDRESS   |        | ATTENDING MEDICAL STAFF<br>PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |                             |  |  |                                     |           |   |      |
| ALAN N. SCHULMAN  |  | 9715 MEDICAL CENTER DRIVE<br>ROCKVILLE, MD. 20850   |        |   |                             |  |  |                                     |           |   |      |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 23b. DATE Oct.<br>Cremation 15, 1985  |        | 23c NAME OF CEMETERY OR CREMATORIAL<br>Metropolitan Crematory   |                             | 23d LOCATION<br>CITY OR TOWN   |  | COUNTY                              |           | STATE   |      |
|   |  |   |        |   |                             | Alexandria   |  | Virginia                            |           |   |      |
| 24 FUNERAL DIRECTOR<br>NAME   |  | Robert A. Pumphrey Funeral Homes,<br>P.A. Bethesda, Maryland  |        | 25a. DATE REC'D. BY REGISTRAR   |                             | 25b. REGISTRAR'S SIGNATURE   |  |                                     |           |   |      |
|   |  |   |        | OCT 16 1985   |                             |  |  |                                     |           |   |      |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be ex-  
hibited by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

4 hours after death Page 4 may be

220



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

298073

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 2896

REG. NO.

|   |  |   |        |   |                          |  |        |                                |        |                        |      |
|---|--|---|--------|---|--------------------------|--|--------|--------------------------------|--------|------------------------|------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   | FIRST  | MIDDLE  | LAST                     | 26. DATE OF DEATH  | MONTH  | DAY                            | YEAR   | 2b. HOUR               |      |
| William   |  |   | W.     |   | Brantley Sr              | 10-18-85   |        |                                |        | 12 <sup>02</sup> A.M.  |      |
| 3. SEX  |  | 4. RACE   |        | 5. DATE OF BIRTH  |                          | 6. AGE   |        | 7 IN YEARS LAST BIRTHDAY       |        | IF UNDER 1 YEAR        |      |
| Male  |  | Caucasian   |        | MONTH DAY YEAR  |                          | 77   |        | YRS                            |        | MONTHS DAYS HOURS MIN. |      |
| 7a. BIRTHPLACE<br>(COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>   |                          | 9. BALTIMORE CITY OR COUNTY OF DEATH   |        |                                |        |                        |      |
| Texas   |  | United States   |        | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |                          | Montgomery County MD.  |        |                                |        |                        |      |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH A FACILITY, GIVE STREET ADDRESS) |        | 12a. USUAL OCCUPATION   |                          | 12b. KIND OF BUSINESS OR<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) INDUSTRY |        |                                |        |                        |      |
| Bethesda  |  | Suburban Hospital   |        | Telephone Maintainer  |                          | Railroad   |        |                                |        |                        |      |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |        |   |                          |  |        |                                |        |                        |      |
| 13a. STATE  |  | 13b. COUNTY   |        | 13c. CITY OR TOWN   |                          | 13d. INSIDE CITY LIMITS?   |        | 13e. STREET ADDRESS / ZIP CODE |        |                        |      |
| Maryland  |  | Montgomery  |        | Bethesda  |                          | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>          |        | 6204 MacArthur Blvd. 20816     |        |                        |      |
| 14. FATHER'S NAME   |  | FIRST   | MIDDLE | LAST  | 15. MOTHER'S MAIDEN NAME |  |        |                                |        |                        |      |
|   |  | Franklin  | Pierce | Honsucker   | FIRST                    |  | Myrtle |                                | MIDDLE |                        | LAST |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | (IF YES, GIVE WAR OR DATES)   |        | 16b. SOCIAL SECURITY NO.  |                          | 17. INFORMANT (Wife)   |        | ADDRESS                        |        |                        |      |
| Yes   |  | 1923-1939   |        | 579-22-2409   |                          | Gloria A. Brantley   |        | 6204 MacArthur Blvd.           |        | Bethesda, Maryland     |      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) _____   |  |   |        |   |                          |  |        |                                |        |                        |      |
| Cardiac arrest<br>immediate   |  |   |        |   |                          |  |        |                                |        |                        |      |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) Probable cerebral thrombosis<br>5 days  |  |   |        |   |                          |  |        |                                |        |                        |      |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |   |        |   |                          |  |        |                                |        |                        |      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.<br>Ventral presutural hydrocephalus - X-ray CT diagnosis   |  |   |        |   |                          |  |        |                                |        |                        |      |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |        | 20a. AUTOPSY?   |                          | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?            |        |                                |        |                        |      |
|   |  |   |        | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                          | YES <input type="checkbox"/> NO <input type="checkbox"/>                     |        |                                |        |                        |      |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |        | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |                          |  |        |                                |        |                        |      |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                      |        | 21f. LOCATION<br>STREET   |                          | CITY OR TOWN   |        | COUNTY                         |        | STATE                  |      |
| 22a. I certify that (I) (the hospital) attended the deceased from 10/12/85 19 85 to 10/14 19 85, that (I) (lost<br>saw the deceased alive on 10/15 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |        |   |                          |  |        |                                |        |                        |      |
| 22b. SIGNATURE  |  | DEGREE  |        | ATTENDING<br>PHYSICIAN <input checked="" type="checkbox"/> MEDICAL<br>DIRECTOR <input type="checkbox"/> STAFF<br>PHYSICIAN <input type="checkbox"/> |                          | 22c. DATE SIGNED   |        |                                |        |                        |      |
| Allen J. O'Neill, MD  |  |   |        |   |                          | 10/18/85   |        |                                |        |                        |      |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS  |        |   |                          |  |        |                                |        |                        |      |
| Allen J. O'Neill, MD  |  | 8601 Old George Town Rd., Bethesda, MD.   |        |   |                          |  |        |                                |        |                        |      |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE October 21, 1985  |        | 23c. NAME OF CEMETERY OR CREMATORIAL<br>Parklawn Memorial Park  |                          | 23d. LOCATION<br>Rockville Montgomery Maryland                               |        |                                |        |                        |      |
| Burial  |  |   |        |   |                          |  |        |                                |        |                        |      |
| 24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Homes,<br>P.A. 7557 Wisconsin Avenue, Bethesda, MD 20814  |  |   |        | 25a. DATE REC'D. BY REGISTRAR OCT 23 1985   |                          | 25b. REGISTRAR'S SIGNATURE   |        |                                |        |                        |      |
|   |  |   |        |   |                          |  |        |                                |        |                        |      |



312055

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the physician or attending physician retain by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please return carbon copies, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other terminal event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |  |  |   |  |  |  |  |  | 85   | 28 | 61    |  |       |                 |                            |      |       |  |  |
|--|--|--|---|--|--|---|--|--|--|--|--|--|----|-------|--|-------|-----------------|----------------------------|------|-------|--|--|
|  |  |  |   |  |  |   |  |  |  |  |  | REG. NO.   |    |       |  |       |                 |                            |      |       |  |  |
| 1 - STATE REGISTRAR  |  |  | 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  | MIDDLE  |  |  | LAST   |  |  | 2a. DATE OF DEATH  |    |       | MONTH  | DAY   | YEAR            | 2b. HOUR 4:15 PM<br>1615PM |      |       |  |  |
|  |  |  | <i>CYNTHIA ANN BREWTON</i>  |  |  |   |  |  |  |  |  | 10-31-85   |    |       |  |       |                 |                            |      |       |  |  |
| 3. SEX   |  |  | 4. RACE   |  |  | 5. DATE OF BIRTH  |  |  | YEAR   |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                |    |       | IF UNDER 1 YEAR  |       | IF UNDER 24 HRS |                            |      |       |  |  |
| Female   |  |  | Caucasian   |  |  | MONTH DAY   |  |  | YEAR   |  |  | 36   |    |       | MONTHS   | YEARS | MONTHS          | HOURS                      | MIN. |       |  |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  |  | 8   |  |  | MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |    |       | MD.  |       |                 |                            |      |       |  |  |
| Washington, DC   |  |  | USA   |  |  | 7 4   |  |  | 49   |  |  | Montgomery County  |    |       |  |       |                 |                            |      |       |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |    |       |  |       |                 |                            |      |       |  |  |
| Takoma Park  |  |  | Washington Adventist Hospital   |  |  |   |  |  | Home maker   |  |  | own home   |    |       |  |       |                 |                            |      |       |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE   |  |  | 13b. COUNTY   |  |  | 13c. CITY OR TOWN   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 13e. STREET ADDRESS / ZIP CODE                                 |    |       |  |       |                 |                            |      |       |  |  |
| Maryland   |  |  | Pr George's   |  |  | Bowie   |  |  | X  |  |  | 4107 Nesconset Drive 20716                                     |    |       |  |       |                 |                            |      |       |  |  |
| 14. FATHER'S NAME<br>FIRST   |  |  | MIDDLE  |  |  | LAST  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST  |  |  | MIDDLE   |    |       | LAST   |       |                 |                            |      |       |  |  |
| Roland   |  |  | G.  |  |  | Martin  |  |  | Ethel  |  |  | Louise   |    |       | Davis  |       |                 |                            |      |       |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   |  |  | 17. INFORMANT   |  |  | 18. APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH  |  |  |  |    |       |  |       |                 |                            |      |       |  |  |
| NO   |  |  | 219-54-5887   |  |  | Stephen B. Brewton  |  |  | 4107 Nesconset Drive   |  |  | Bowie, MD 20716  |    |       |  |       |                 |                            |      |       |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b) and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)                             |  |  |   |  |  |   |  |  |  |  |  | <i>Mycophagy failure</i>                                       |    |       |  |       |                 |                            |      |       |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b)  |  |  |   |  |  |   |  |  |  |  |  | <i>Chronic myelogenous leukemia, blast crisis</i>              |    |       |  |       |                 |                            |      |       |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |  |   |  |  |   |  |  |  |  |  |  |    |       |  |       |                 |                            |      |       |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a                           |  |  |   |  |  |   |  |  |  |  |  |  |    |       |  |       |                 |                            |      |       |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                 |  |  |  |    |       |  |       |                 |                            |      |       |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)       |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |  |  |  |    |       |  |       |                 |                            |      |       |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  |  | 21f. LOCATION<br>STREET   |  |  | CITY OR TOWN   |  |  | COUNTY   |    | STATE |  |       |                 |                            |      |       |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from<br>saw the deceased alive on above, (I) (we) (did) (did not) view the body after death, |  |  | 22b. SIGNATURE<br><i>Martin J. Weller</i>   |  |  | 22c. DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  | 22d. DATE SIGNED<br>11/1/85  |  |  |  |    |       |  |       |                 |                            |      |       |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Martin J. Weller</i>   |  |  | 22e. ADDRESS<br>7825 Greenway Dr. On Greenbelt MD 20701   |  |  | 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation   |  |  | 23b. DATE<br>Nov 1, 1985   |  |  | 23c. NAME OF CEMETERY OR CREMATORIAL<br>Metropolitan Crematory |    |       | 23d. LOCATION<br>CITY OR TOWN<br>Alexandria, Fairfax, Virginia |       |                 | COUNTY                     |      | STATE |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Beall Funeral Home   |  |  | 16000 Annapolis Rd.   |  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 06 1985  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Leah Chiles</i>   |  |  |  |    |       |  |       |                 |                            |      |       |  |  |

315022

| Category            | Series                |
|---------------------|-----------------------|
| Non-DW-IA Grants    | 100                   |
| Applicant Name      | John D. Gandy         |
| Project Title       | Advanced Technology   |
| Project Description | Non-Water             |
| Project Type        | Software              |
| Project Dates       | 10/1/2000 - 10/1/2001 |
| Project Manager     | John D. Gandy         |
| Project Lead        | John D. Gandy         |
| Project Status      | Completed             |
| Project Cost        | \$10,000              |
| Project Number      | 100-0000000000000000  |
| Project Description | Advanced Technology   |
| Project Type        | Software              |
| Project Dates       | 10/1/2000 - 10/1/2001 |
| Project Manager     | John D. Gandy         |
| Project Lead        | John D. Gandy         |
| Project Status      | Completed             |
| Project Cost        | \$10,000              |
| Project Number      | 100-0000000000000000  |

297024

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

85 28 96 2

REG. NO.

1- STATE  
REGISTRAR

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT; PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

|  |                                  |  |   |  |   |  |                |   |            |                |
|--|----------------------------------|--|---|--|---|--|----------------|---|------------|----------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |                                  |  | FIRST<br><b>Jesse</b>   | MIDDLE<br><b>Norman</b>  | LAST<br><b>Brice</b>  | 2a. DATE KNOWN<br>OF ESTI-<br>MATED<br><input checked="" type="checkbox"/>             | MONTH<br>10/11 | DAY<br>19   | YEAR<br>85 | 27 1/2<br>A.M. |
| 3. SEX   | 4. RACE                          | 5. DATE OF BIRTH<br>MONTH DAY YEAR   | 6. AGE (IN YEARS<br>LAST BIRTHDAY)<br>52 YRS.   | 7. IF UNDER 1 YR.<br>MONTHS DAYS   | 8. IF UNDER 24 HRS.<br>HOURS MIN  | 2c. DATE<br>PRONOUNCED<br>DEAD<br><input checked="" type="checkbox"/>                  | MONTH<br>10/11 | DAY<br>19   | YEAR<br>85 | 27 1/2<br>A.M. |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)<br><b>Washington, D.C.</b>  |                                  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED<br><input checked="" type="checkbox"/> NEVER MARRIED<br><input type="checkbox"/><br>WIDOWED<br><input type="checkbox"/><br>DIVORCED<br><input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County</b>                       |                |   |            |                |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring</b>  |                                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1135 University Boulevard West, Upholsterer</b> |   |  | #401  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)<br><b>Upholsterer</b> |                | 12b. KIND OF BUSINESS<br>OR INDUSTRY<br><b>Decorating</b> |            |                |
| 13a. STATE<br><b>Maryland</b>  | 13b. COUNTY<br><b>Montgomery</b> | 13c. CITY OR TOWN<br><b>Silver Spring</b>  | 13d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | 13e. STREET ADDRESS<br><b>20902 #401</b>   | 13f. ADDRESS<br><b>656-50th Place, S.E. Washington, D.C. 20019</b>                  |  |                |   |            |                |
| 14. FATHER'S NAME<br>FIRST<br><b>Jesse</b>   |                                  | MIDDLE<br><b>J.</b>  | LAST<br><b>Brice</b>  | 15. MOTHER'S MAIDEN NAME<br>FIRST<br><b>Mary</b>   |   | 16. APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                    |                |   |            |                |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>Yes</b>  |                                  | 16b. SOCIAL SECURITY NO.<br><b>1953-42-3933</b>  |   | 17. INFORMANT<br><b>Margaret Brice</b>   |   |  |                |   |            |                |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute myocardial disease.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a) stating the <u>under-</u><br>lying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |                                  |  |   |  |   |  |                |   |            |                |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I<br><b>None</b>  |                                  |  |   |  |   |  |                |   |            |                |
| 19a. DATE OF OPERATION<br><b>None</b>  |                                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |  | 20. AUTOPSY?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |                |   |            |                |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>None</b>   |   |  |                |   |            |                |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |                                  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)   |   | 21f. LOCATION<br>STREET  |   | CITY OR TOWN   |                | COUNTY  | STATE      |                |
| 22a. I certify that I took charge of the remains described above, held an<br>death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/><br>Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion<br>Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                                  |  |   |  |   |  |                |   |            |                |
| TITLE (SPECIFY)<br><b>Deputy M.D.</b> MEDICAL EXAMINER<br><b>1919 Seminary Road</b><br>EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>John S. Rogers, M.D.</b> ADDRESS <b>Silver Spring, Montgomery County, Md.</b>  |                                  |  |   |  |   |  |                |   |            |                |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |                                  | 23b. DATE<br><b>10/18/85</b>   |   | 23c. NAME OF CEMETERY OR CREMATORIAL<br><b>Harmony Memorial Park</b>   |   | 23d. LOCATION<br>CITY OR TOWN<br><b>Landover Prince George's MD</b>                    |                | COUNTY  | STATE      |                |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>ROLLINS FUNERAL HOME, INC.</b><br>ADDRESS<br><b>4339 HUNT PLACE, N.E.</b>   |                                  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT. 18 1985</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Julie Taylor Rogers</b>   |   |  |                |   |            |                |
| WASHINGTON, D.C. 20019   |                                  |  |   |  |   |  |                |   |            |                |

COLLECTIVE WORKS HOME, INC.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

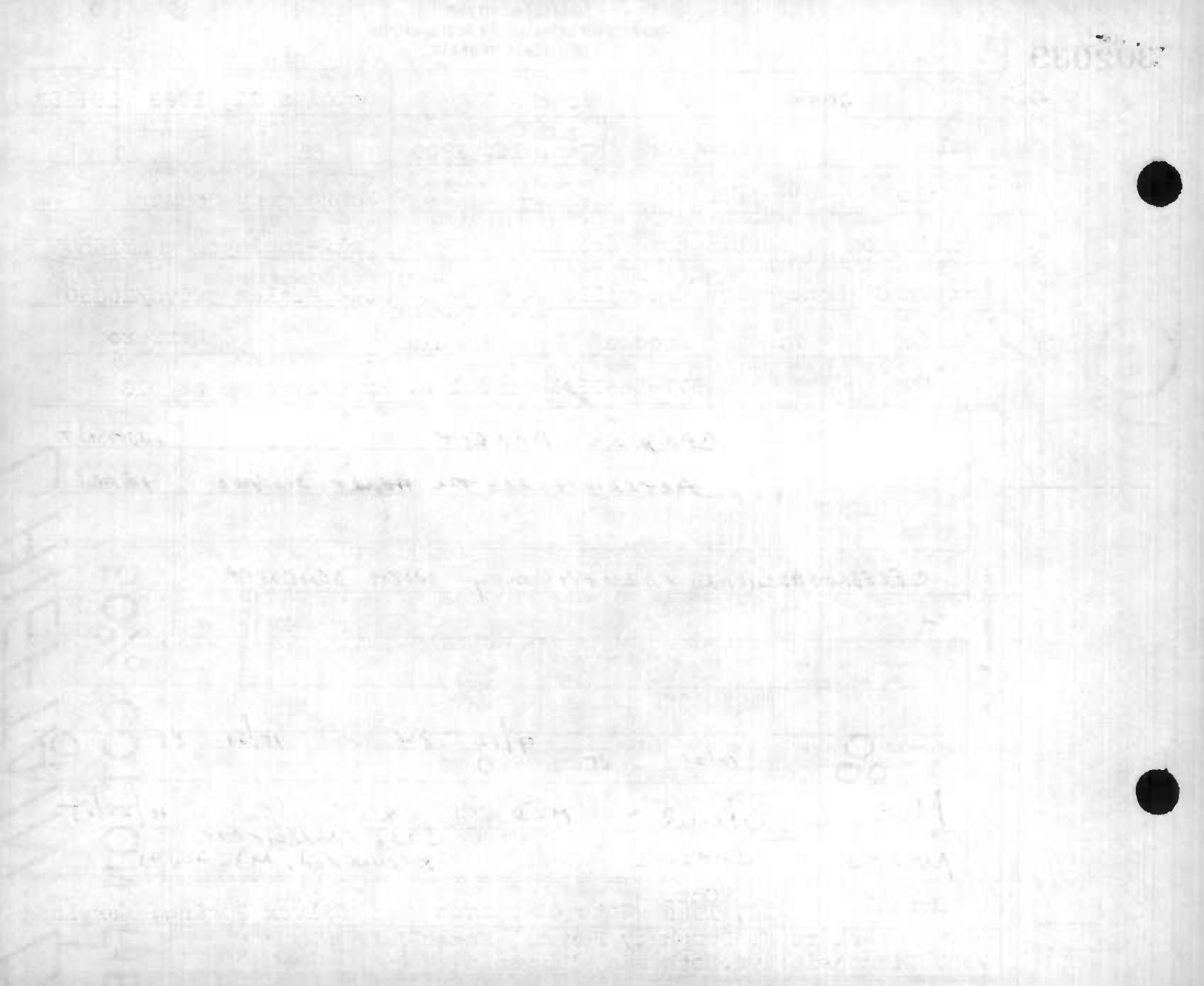
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |       |  |      |  |                   |   |       | REG. NO.         |      |  |  |
|--|--|---|-------|--|------|--|-------------------|---|-------|------------------|------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   | FIRST | MIDDLE   | LAST |  | 2d. DATE OF DEATH |   | MONTH | DAY              | YEAR | 2b. HOUR   |  |
| Jose P. Broche   |  |   |       |  |      |  | October 21, 1985  |   |       |                  |      | 10:15PM  |  |
| 3 SEX  |  | 4 RACE  |       | 5. DATE OF BIRTH   |      | 6. AGE (IN YEARS LAST BIRTHDAY)  |                   | IF UNDER 1 YEAR   |       | IF UNDER 24 HRS. |      |  |  |
| Male   |  | Caucasian   |       | Month Day Year<br>Jan. 16, 1900  |      | 85   |                   | MONTHS DAYS   |       | HOURS MIN.       |      |  |  |
| 7a BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)   |  | 7b CITIZEN OF WHAT COUNTRY?   |       | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |      | 9 BALTIMORE CITY OR COUNTY OF DEATH  |                   | YRS   |       |                  |      |  |  |
| Cuba   |  | Cuba  |       |  |      | Montgomery County  |                   |   |       |                  |      |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN THIS FACILITY, GIVE STREET ADDRESS) |       | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |      | 12b KIND OF BUSINESS OR<br>INDUSTRY  |                   | MD.   |       |                  |      |  |  |
| Kensington   |  | Kensington Gardens  |       | Self-employed  |      | Merchant Marine  |                   |   |       |                  |      |  |  |
| 13a STATE<br>Maryland  |  | 13b COUNTY<br>Montgomery  |       | 13c CITY OR TOWN<br>Rockville  |      | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                   | 13e STREET ADDRESS / ZIP CODE<br>544 Azalea Drive/20850 |       |                  |      |  |  |
| 14. FATHER'S NAME<br>FIRST<br>Daniel   |  | MIDDLE<br>R.  |       | LAST<br>Broche   |      | 15. MOTHER'S MAIDEN NAME<br>FIRST<br>Angela  |                   | MIDDLE  |       | LAST<br>Marrero  |      |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>577-86-3391                                     |       | 17 INFORMANT<br>Daniel A. Broche, same as #13  |      | ADDRESS  |                   |   |       |                  |      |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)  |  | CARDIAC ARREST  |       |  |      |  |                   |   |       |                  |      | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>INSTANT |  |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause lost.  |  | DUE TO, OR AS A CONSEQUENCE OF<br>(b) ARTERIOSCLEROTIC HEART DISEASE                                      |       | YEARS  |      |  |                   |   |       |                  |      |  |  |
| {  |  | DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |       |  |      |  |                   |   |       |                  |      |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).  |  |   |       |  |      |  |                   |   |       |                  |      |  |  |
| CEREBROVASCULAR INSUFFICIENCY WITH DEMENTIA  |  |   |       |  |      |  |                   |   |       |                  |      |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |       | 20a. AUTOPSY?  |      | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?                              |                   |   |       |                  |      |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |      | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |                   |   |       |                  |      |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |       | 21f. LOCATION<br>STREET  |      | CITY OR TOWN   |                   | COUNTY  |       | STATE            |      |  |  |
| 22a. I certify that (1) this hospital attended the deceased from 9/12, 1984, to 10/21, 1985, that (1) we last saw the deceased alive on 10/21, 1985, and that in (1) our opinion death occurred on the date and hour and from the causes stated above, (1) we did (did not) view the body after death. |  |   |       |  |      |  |                   |   |       |                  |      |  |  |
| 22b. SIGNATURE<br>Martin C. Sharpe   |  | DEGREE<br>M.D.  |       | ATTENDING<br>PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF<br>PHYSICIAN <input type="checkbox"/>                   |      | 22c. DATE SIGNED<br>10/22/85   |                   |   |       |                  |      |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Martin C. Sharpe  |  | 22e. ADDRESS<br>3720 Fairmount Ave.<br>KENSINGTON, MD - 20895   |       |  |      |  |                   |   |       |                  |      |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>Oct. 24, 1985  |       | 23c. NAME OF CEMETERY OR CREMATORIAL<br>Gate of Heaven   |      | 23d. LOCATION<br>CITY OR TOWN<br>Silver Spring, Maryland                                       |                   | COUNTY  |       |                  |      | STATE  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Robert A. Pumphrey Funeral Home<br>7557 Wisconsin Ave. Bethesda, Maryland  |  | 25. DATE REC'D. BY REGISTRAR<br>OCT 25 1985   |       | 26. REGISTRAR'S SIGNATURE<br>John P. Sharpe  |      |  |                   |   |       |                  |      |  |  |
| DHMH - 16 50M 4/83<br>(VRA 15, 4)  |  |   |       |  |      |  |                   |   |       |                  |      |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## 1 - STATE REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 85-28964

|   |  |   |        |  |  |   |  |  |   |                                      |          |  |
|---|--|---|--------|--|--|---|--|--|---|--------------------------------------|----------|--|
| 1a. DECEASED NAME<br>(TYPE OR PRINT)  |  |   |        | FIRST  | MIDDLE   | LAST  | 2a. DATE OF DEATH  | MONTH  | DAY   | YEAR                                 | 2b. HOUR |  |
| Winfred Willard Brown   |  |   |        |  |  |   | 10/20/85   |  |   |                                      | 12:50 pm |  |
| 3. SEX  |  | 4. RACE   |        | 5. DATE OF BIRTH   |  |   | 6. AGE (IN YEARS LAST BIRTHDAY)                                  |  |   | IF UNDER 1 YEAR                      |          |  |
| Male  |  | White   |        | Nov. 24, 1925  |  |   | 59   |  |   | MONTHS                               | YEARS    |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |        | 8. MARRIED   |  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH                             |  |   | IF UNDER 24 HRS.                     |          |  |
| Maryland  |  | USA   |        | <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br><input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED |  |   | Montgomery County  |  |   | MONTHS                               | HOURS    |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |        |  |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY |          |  |
| Olney   |  | Montgomery General Hospital   |        |  |  |   | Farmer   |  |   | Farming                              |          |  |
| 13a. STATE  |  | 13b. COUNTY   |        | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  |  | 13e. STREET ADDRESS / ZIP CODE                                    |                                      |          |  |
| Maryland  |  | Montgomery  |        | Damascus   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  | 20872<br>12631 Prices Distillery Rd.                              |                                      |          |  |
| 14. FATHER'S NAME   |  | FIRST   | MIDDLE | LAST   | 15. MOTHER'S MAIDEN NAME   |   |  | FIRST  | MIDDLE  | LAST                                 |          |  |
|   |  | Willard   | H.     | Brown  |  |   |  | Sarah  | Elizabeth   | King                                 |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |        | 17. INFORMANT  |  |   | ADDRESS  |  |   |                                      |          |  |
| No  |  | 214-28-1108   |        | Ann E. Brown, Item 13  |  |   |  |  |   |                                      |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for Part 1 and 2)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardiac pulmonary arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Severe Chronic Ischemic pulm. dis.</u> APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>udden</u>   |  |   |        |  |  |   |  |  |   |                                      |          |  |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause last  |  |   |        |  |  |   |  |  |   |                                      |          |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |   |        |  |  |   |  |  |   |                                      |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a<br><u>Respiratory insufficiency, cor pulmonale, left heart failure, cardiogenic shock</u>  |  |   |        |  |  |   |  |  |   |                                      |          |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |        |  |  |   | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH? |                                      |          |  |
|   |  |   |        |  |  |   | <input type="checkbox"/> NO <input type="checkbox"/>             |  | YES <input type="checkbox"/> NO <input type="checkbox"/>          |                                      |          |  |
| 21a. ACCIDENT WAS UNDERLYING<br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |        |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |   |                                      |          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |        |  | 21f. LOCATION<br>STREET  |   |  | CITY OR TOWN                                 | COUNTY  | STATE                                |          |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>10/20</u> , 19 <u>85</u> , to <u>10/20</u> , 19 <u>85</u> , that (I) (we) lost<br>soul the deceased alive on <u>10/20</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death. |  |   |        |  |  |   |  |  |   |                                      |          |  |
| 22b. SIGNATURE<br><u>Donald E Dillon, M.D.</u>  |  | 22c. DEGREE<br><u>M.D.</u>  |        |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  | 22d. DATE SIGNED<br><u>20 Oct 85</u>         |   |                                      |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Donald E Dillon, M.D.</u>   |  | 22e. ADDRESS<br><u>2901 0 Bay-Sandy Spring Rd<br/>Olney MD 20832</u>                                      |        |  |  |   |  |  |   |                                      |          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>Oct. 23, 1985  |        | 23c. NAME OF CEMETERY OR CREMATORIAL<br>Mt. View   |  |   | 23d. LOCATION<br>CITY OR TOWN<br>Damascus                        |  | COUNTY  | STATE                                |          |  |
| 24. FUNERAL DIRECTOR<br>Olin L. Molesworth, P.A., Damascus, Md.   |  | 25a. ADDRESS<br>APPROX.<br>Olin L. Molesworth, P.A., Damascus, Md.  |        |  | 25b. DATE REC'D. BY REGISTRAR<br>OCT 23 1985   |   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Johanna</u> |   |                                      |          |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached from the burial permit. Then please remove the paper. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner will be informed at death.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 8528965

|   |   |   |   |                   |   |  |   |  |                                   |
|---|---|---|---|-------------------|---|--|---|--|-----------------------------------|
| DECEASED NAME<br>(TYPE OR PRINT)  | FIRST   | MIDDLE  | LAST  | 2a. DATE OF DEATH | MONTH   | DAY  | YEAR  | 2b. HOUR   |                                   |
| Constance I Brownfield  |   |   |   | 10-20-85          |   |  |   | 6:57 AM M  |                                   |
| 3. SEX  | 4. RACE   | 5. DATE OF BIRTH  |   |                   | 6. AGE (IN YEARS LAST BIRTHDAY)                 |  |   | 7. IF UNDER 1 YEAR   |                                   |
| Female  | Caucasian   | MONTH   | DAY   | YEAR              | 50  | YRS.   | MONTHS  | DAYS   | IF UNDER 24 HRS                   |
| 7a. BIRTHPLACE<br>COUNTRY   | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |                   | 9. BALTIMORE CITY OR COUNTY OF DEATH            |  |   | MD.  |                                   |
| Maryland  | USA   |   |   |                   | Montgomery                                      |  |   |  |                                   |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH A CITY, GIVE STREET ADDRESS) |   |   |                   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     |   |  | 12b. KIND OF BUSINESS OR INDUSTRY |
| Takoma Park   | 8003 Flower Ave.  |   |   |                   |   | HOMEMAKER  |   |  | 20912                             |
| 13a. STATE  | 13b. COUNTY   | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                   |   | 13e. STREET ADDRESS / ZIP CODE   |   |  |                                   |
| Maryland  | Montgomery  | Takoma Park   |   |                   |   | 803 Flower Ave.  |   |  |                                   |
| 14. FATHER'S NAME   | MIDDLE  | AS  | 15. MOTHER'S MAIDEN NAME  |                   |   | ADDRESS  |   |  |                                   |
| Raymond   |   | Rife  | NELLIE MILDRED  |                   |   | SAME   |   |  |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)   | 16b. SOCIAL SECURITY NO.  | 17. INFORMANT   |   |                   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |   |  |                                   |
| NO  | 579-38-8648   | Husband   |   |                   | 2-3 yrs.  |  |   |  |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinomatosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Carcinoma of colon</u><br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |   |   |   |                   |   |  |   | 9 yrs.   |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |   |   |   |                   |   |  |   |  |                                   |
| 19a. DATE OF OPERATION<br><u>June 1984</u>  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   |                   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |                   |   |  |   |  |                                   |
| 21d. INJURY OCCURRED<br><input type="checkbox"/> AT HOME <input type="checkbox"/> NOT HOME <input type="checkbox"/> AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                  | 21f. LOCATION<br>STREET   |   |                   | CITY OR TOWN                                    | COUNTY   | STATE   |  |                                   |
| 22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from <u>July 19 76</u> , to <u>Oct. 19 85</u> , that <input type="checkbox"/> (we) last<br>saw the deceased alive on <u>Oct 10 1985</u> , and that in <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated<br>above. <input type="checkbox"/> (we) did not view the body after death. |   |   |   |                   |   |  |   | 22c. DATE SIGNED<br><u>10-20-85</u>  |                                   |
| 22b. SIGNATURE<br><u>James R. Coleman MD</u> DEGREE   |   |   |   |                   |   |  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                   |
| 22e. ADDRESS<br><u>9241 COLUMBIA BLVD<br/>SILVER SPRING, MARYLAND 20910</u>   |   |   |   |                   |   |  |   |  |                                   |
| 23a. BURIAL, CREMATION, REMOVAL<br>SPECIFIC   | 23b. DATE<br><u>Oct. 22, 1985</u>   | 23c. NAME OF CEMETERY OR CREMATORIUM<br><u>George Washington Cemetery</u>   |   |                   | 23d. LOCATION<br><u>Takoma Funeral Home</u>     | 23e. COUNTIES<br><u>Montgomery</u>   |   |  |                                   |
| 24. FUNERAL DIRECTOR<br><u>Nellie Kellers</u>   | 25a. DATE REC'D. BY REGISTRAR IN REGISTER'S SIGNATURE<br><u>OCT 23 1985</u>                             |   |   |                   |   | 25b. PLACE REC'D.<br><u>George Washington Cemetery</u>                               |   |  |                                   |
| 25c. DHMH - 16 50M 4/83<br>(VRA 15, 4)  |   |   |   |                   |   |  |   |  |                                   |

SCALES

ABDUCTION

Abduction =  $\frac{1}{2}$  of the distance from the head of the humerus to the glenoid cavity.

DEPRESSION

Depression = Head of the humerus - Abduction

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |                                  |   |  |  |   |  |                 |          |                 |      |
|--|--|--|--|----------------------------------|---|--|--|---|--|-----------------|----------|-----------------|------|
| 1 - STATE REGISTRAR  |  |  |  |                                  |   |  |  |   |  |                 | REG. NO. |                 |      |
| I. DECEASED NAME<br>(TYPE OR PRINT)  |  |  | FIRST  | MIDDLE                           | LAST  | 2d. DATE OF DEATH  |  |   | MONTH  | DAY             | YEAR     | 2b. HOUR        |      |
| EDITH LAURA 13 Royles  |  |  |  |                                  |   | 10/11 85   |  |   |  |                 |          | 11 am           |      |
| 3. SEX   |  |  | 4. RACE  |                                  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                        |   |  | IF UNDER 1 YEAR |          | IF UNDER 24 HRS |      |
| Female   |  |  | White  |                                  | Month Day Year<br>April 14, 1911  |  | 74   |   |  | MONTHS          | DAYS     | HOURS           | MIN. |
| 7a. BIRTHPLACE<br>COUNTRY<br>N.C.  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |                                  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD. |   |  |                 |          |                 |      |
| 10. CITY OR TOWN OF DEATH<br>Bethesda  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SUBURBAN Hosp |                                  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Clerical  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Telephone Co.          |  |                 |          |                 |      |
| 13a. STATE<br>Md.  |  |  | 13b. COUNTY<br>Montgomery  | 13c. CITY OR TOWN<br>Chevy Chase | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  | 13e. STREET ADDRESS / ZIP CODE<br>5480 Wisconsin Ave. 20815 |  |                 |          |                 |      |
| 14. FATHER'S NAME<br>FIRST<br>John   |  |  | MIDDLE<br>Taylor   | LAST<br>Corbin                   | 15. MOTHER'S MAIDEN NAME<br>FIRST<br>Allie  |  |  | MIDDLE<br>Mae   | LAST<br>Miller   |                 |          |                 |      |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>212-10-0321-4   |                                  | 17. INFORMANT<br>Stephen R. Broyles Chevy Chase, Md.  |  |  | ADDRESS<br>5480 Wisconsin Ave.                              |  |                 |          |                 |      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>acute massive myocardial infarction</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>constrictive pericarditis</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>cardiac arrhythmia</i><br>APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |  |  |                                  |   |  |  |   |  |                 |          |                 |      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |                                  |   |  |  |   |  |                 |          |                 |      |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                  |   | 20a. AUTOPSY?  |  |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                 |          |                 |      |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |                                  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                 |          |                 |      |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>1811   |                                  |   | 21f. LOCATION<br>STREET<br>CITY OR TOWN<br>COUNTY<br>STATE   |  |   |  |                 |          |                 |      |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/26/85</u> to <u>10/11/85</u> , 19_____, that (I) (we) last saw the deceased alive on <u>10/11/85</u> , 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                           |  |  |  |                                  |   |  |  |   |  |                 |          |                 |      |
| 22b. SIGNATURE<br><i>J-9. Lawrence</i>   |  |  | 22c. DEGREE<br>MD  |                                  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   | 22d. DATE SIGNED   |                 |          |                 |      |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br>EDWARD J. KNIGHT MD   |  |  | 22f. ADDRESS<br>5218 Wisconsin Ave., Bethesda, MD  |                                  |   |  |  |   |  |                 |          |                 |      |
| 23a. BURIAL, CREMATION, REMOVAL<br>Burial/Removal  |  |  | 23b. DATE<br>10/2/1985   |                                  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Forest Lawn Cemetery   |  |   | 23d. LOCATION<br>CITY OR TOWN<br>Buncombe Co. N.C.   |                 |          |                 |      |
| 24. FUNERAL DIRECTOR<br>NAME<br>Joseph Gawler's Sons   |  |  | ADDRESS<br>5130 Wisc. Ave. N.W.<br>Washington, D.C. 20004  |                                  |   | DATE REC'D. BY REGISTRAR<br>10/04/1985   |  |   | 25. REGISTRAR'S SIGNATURE<br><i>Sandra Johnson</i>   |                 |          |                 |      |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copy from page 1. Item 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the doctor certifying the cause of death must sign this section.

283130

1825

ERIC, Full Text Provided by ERIC

### **Choice**

ST5-300 - J-A - Section B - Benefits

296080

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 is checked, attach a medical examiner's report.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |                          |                          |  |  |       |   |   |   | REG. NO.   |   |                                      |  |
|--|--|---|--|--------------------------|--------------------------|--|--|-------|---|---|---|--|---|--------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   | FIRST  | MIDDLE                   | LAST                     | 2a. DATE OF DEATH  |  |       | MONTH   | DAY   | YEAR  | 2b. HOUR   |   |                                      |  |
| <b>DO BENJAMIN</b>   |  |   | <b>BRUCE</b>   | <b>BRUMBAUGH</b>         |                          | <b>Oct 18 85</b>   |  |       |   |   | 11:00 A.M.  |  |   |                                      |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH         |                          |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |       |   | IF UNDER 1 YEAR                             |   | 2b. HOUR   |   |                                      |  |
| MALE   |  | WHITE   |  | MONTH                    | DAY                      | YEAR   | 95   |       |   | MONTHS                                      | DAYS  | 11:00 A.M.   |   |                                      |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8                        |                          |  | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |       |   | 9 BALTIMORE CITY OR COUNTY OF DEATH         |   |  |   |                                      |  |
| Maryland   |  | U.S.A.  |  |                          |                          |  |  |       |   | Montgomery County                           |   |  | MD.   |                                      |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                          |                          |  |  |       |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY |  |
| Rockville  |  | Potomac Nursing Center  |  |                          |                          |  |  |       |   |   |   | Doctor   |   | Self-Employed                        |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |                          |                          |  |  |       |   |   |   |  |   |                                      |  |
| 13a. STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN        |                          |  | 13d. INSIDE CITY LIMITS?   |       |   | 13e. STREET ADDRESS / ZIP CODE              |   |  |   |                                      |  |
| Maryland   |  | Howard  |  | Elkridge                 |                          |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |       |   | 5825 Main Street 21227                      |   |  |   |                                      |  |
| 14. FATHER'S NAME  |  | FIRST   | MIDDLE   | LAST                     | 15. MOTHER'S MAIDEN NAME |  |  | FIRST | MIDDLE  | LAST  |   |  |   |                                      |  |
|  |  | Benjamin  | B.   | Brumbaugh                |                          |  |  | Anna  |   |   |   |  |   |                                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | (IF YES, GIVE WAR OR DATES)   |  | 16b. SOCIAL SECURITY NO. |                          |  | 17. INFORMANT  |       |   | ADDRESS                                     |   |  |   |                                      |  |
| YES  |  | WW I  |  | 220-44-0840              |                          |  | Vernon Brumbaugh   |       |   | 101 Croydon Ct. 20909                       |   |  |   |                                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |  |   |  |                          |                          |  |  |       |   |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |                                      |  |
| PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Stroke (Cerebrovascular Hemorrhage)</u> 72 hrs   |  |   |  |                          |                          |  |  |       |   |   |   |  |   |                                      |  |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause lost.<br>(b) <u>Atherosclerotic cerebral vasculitis</u> 20 yrs   |  |   |  |                          |                          |  |  |       |   |   |   |  |   |                                      |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u>  |  |   |  |                          |                          |  |  |       |   |   |   |  |   |                                      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |  |                          |                          |  |  |       |   |   |   |  |   |                                      |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                          |                          |  |  |       | 20a. AUTOPSY?   |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH? |  |   |                                      |  |
|  |  |   |  |                          |                          |  |  |       | YES <input type="checkbox"/> NO <input type="checkbox"/>      |   | YES <input type="checkbox"/> NO <input type="checkbox"/>          |  |   |                                      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR                        |                          |                          | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |       |   |   |   |  |   |                                      |  |
|  |  |   | P.M. 19  |                          |                          |  |  |       |   |   |   |  |   |                                      |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                          |                          | 21f. LOCATION<br>STREET  |  |       | CITY OR TOWN  | COUNTY                                      | STATE   |  |   |                                      |  |
| 22a. I certify that (I) (we) attended the deceased from<br>saw the deceased alive on <u>17 Oct 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) did (did not) view the body after death |  |   |  |                          |                          |  |  |       |   |   |   |  |   |                                      |  |
| 22b. SIGNATURE<br><u>Paul T. Noone</u>   |  |   | DEGREE<br><u>MD</u>  |                          |                          | ATTENDING<br>PHYSICIAN <input checked="" type="checkbox"/>                     |  |       | MEDICAL<br>DIRECTOR <input type="checkbox"/>                  | STAFF<br>PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED<br><u>10/18/85</u>                               |  |   |                                      |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Paul T. Noone MD</u>   |  |   | 22e. ADDRESS<br><u>500 E. Ellicott St. B. Rowell</u>                   |                          |                          |  |  |       |   |   |   |  |   |                                      |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  |   | 23b. DATE<br><u>10/21/85</u>   |                          |                          | 23c. NAME OF CEMETERY OR CREMATORIAL<br><u>Jarrettsville Cemetery</u>          |  |       | 23d. LOCATION<br>CITY OR TOWN<br><u>Jarrettsville Harford</u> |   |   | STATE<br><u>Md.</u>  |   |                                      |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>Hubbard Funeral Home, Inc.</u>  |  |   | ADDRESS<br><u>4107 Wilkins Ave.</u>                                    |                          |                          | 25a. DATE REC'D. BY REGISTRAR<br><u>OCT 21 1985</u>                            |  |       | 25b. REGISTRAR'S SIGNATURE<br><u>John Anderson Jr.</u>        |   |   |  |   |                                      |  |

executed within 24 hours after death

page 3

should be filed with the State Dept. of Health and Mental Hygiene

prior to burial, cremation, or removal

129323



310024

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |   |   |   |  |   |   |                                      |                              |
|---|---|---|---|--|---|---|--------------------------------------|------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |   |   | FIRST<br><i>MARY</i>  | MIDDLE<br><i>Christine</i>   | LAST<br><i>BRYANT</i>   | 2a DATE OF DEATH<br><i>10/24/85</i>   | MONTH<br>YEAR                        | 2b. HOUR<br><i>1:53 A.M.</i> |
| 3 SEX<br><i>Female</i>  | 4. RACE<br><i>NEGRO</i>   | 5. DATE OF BIRTH<br>MONTH<br><i>12</i>  | DAY<br><i>25</i>  | YEAR<br><i>10</i>  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><i>74</i><br>YRS.   | IF UNDER 1 YEAR<br>MONTHS<br><i>0</i>   | IF UNDER 24 HRS<br>HOURS<br><i>0</i> | MIN.<br><i>0</i>             |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Virginia</i>  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>MONTGOMERY CO.</i>   |   |                                      |                              |
| 10. CITY OR TOWN OF DEATH<br><i>Bethesda</i>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>SUBURBAN HOSPITAL</i> |   |   |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Domestic</i> |                                      |                              |
| 13a. STATE<br><i>Maryland</i>   | 13b. COUNTY<br><i>Montgomery</i>  | 13c. CITY OR TOWN<br><i>Gaithersburg</i>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><i>301 Russell Ave 20878</i>                       |   |   |                                      |                              |
| 14. FATHER'S NAME<br>FIRST<br><i>Joseph</i>   | MIDDLE<br><i></i>   | LAST<br><i>Trammell</i>   | 15. MOTHER'S MAIDEN NAME<br>FIRST<br><i>Lillie</i>  |  |   |   |                                      |                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>no</i>   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><i>044-26-0355</i>   | 17. INFORMANT<br><i>Harry O. Bryant</i>   |   |  | ADDRESS<br><i>Fred., Md. 21701<br/>1412 Rolling House Rd.</i>   |   |                                      |                              |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)   |   |   | TERMINAL CONGESTIVE HEART FAILURE 3 YEARS<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH       |  |   |   |                                      |                              |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |   |   | DUE TO, OR AS A CONSEQUENCE OF<br>(b) PROBABLY CANCER OF THE LUNG 1 YEAR                        |  |   |   |                                      |                              |
|   |   |   | DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |   |   |                                      |                              |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><br>TERMINAL ARTERIOSCLEROSIS   |   |   |   |  |   |   |                                      |                              |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |                                      |                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |   |   |                                      |                              |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET   | CITY OR TOWN  |  | COUNTY  | STATE   |                                      |                              |
| 22a. I certify that (I) (this hospital) attended the deceased from 1980, 19, to 1985, 19, that (I) (we) last saw the deceased alive on 10/23/85, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |   |   |   |  |   |   |                                      |                              |
| 22b. SIGNATURE<br><i>[Signature]</i>  | DEGREE<br><i>MD</i>   | ATTENDING PHYSICIAN<br><i>X</i>   | MEDICAL DIRECTOR <input type="checkbox"/>   | STAFF PHYSICIAN <input type="checkbox"/>   | 22c. DATE SIGNED<br><i>10/24/85</i>   |   |                                      |                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>DR. OSOTH LEKAGUL</i>   | 22e. ADDRESS<br><i>7425 Arlington Rd, Bethesda, MD</i>  |   |   |  |   |   |                                      |                              |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIES)<br><i>Burial</i>   | 23b. DATE<br><i>10-28-85</i>  | 23c. NAME OF CEMETERY OR CREMATORIAL<br><i>Mt. Olive Cemetery</i>   | 23d. LOCATION<br>CITY OR TOWN<br><i>Lincoln</i>   | 23e. COUNTY<br><i>Loudoun</i>  | 23f. STATE<br><i>Virginia</i>   |   |                                      |                              |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Loudoun Funeral Chapel</i>   | P.O. Box 1316<br>Leesburg, Virginia   | 22075<br>ADDRESS<br><i>Leesburg, Virginia</i>   | 25a. DATE REC'D. BY REGISTRAR<br><i>OC 129 1985</i>   | 25b. REGISTRAR'S SIGNATURE<br><i>J. L. Wilson</i>                                    |   |   |                                      |                              |

FS901G



297026

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSPIRANT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DIVISION OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                              |        |                                   |   |                   |                                   |   |                          |                          |   |  |      | REG. NO.   |   |  |  |  |  |   |  |  |
|--|--------|-----------------------------------|---|-------------------|-----------------------------------|---|--------------------------|--------------------------|---|--|------|--|---|--|--|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |        |                                   | FIRST   | MIDDLE            | LAST                              | 2a. DATE KNOWN<br>OF ESTI.<br>DEATH MATED   |                          |                          | MONTH   | DAY  | YEAR | 2b. HOUR<br>11:09 AM   |   |  |  |  |  |   |  |  |
| HENRY C BURRIS   |        |                                   |   |                   |                                   | <input checked="" type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | 10  | 9  | 1985 |  |   |  |  |  |  |   |  |  |
| 3 SEX  | 4 RACE | 5 DATE OF BIRTH<br>MONTH DAY YEAR | 6. AGE (IN YEARS<br>LAST BIRTHDAY)  | 7. IF UNDER 1 YR. | 8. IF UNDER 24 HRS.               | MONTHS  | DAYS                     | HOURS                    | MIN.  | 2c. DATE<br>PRONOUNCED<br>DEAD   |      |  | 2d. HOUR<br>11:09 AM  |  |  |  |  |   |  |  |
| M  | WHITE  | 4 18 10                           | 75 yrs.   |                   |                                   |   |                          |                          |   | 10 9   | 1985 |  |   |  |  |  |  |   |  |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)   |        |                                   | 7b. CITIZEN OF WHAT COUNTRY?  |                   |                                   | 8. MARRIED<br><input checked="" type="checkbox"/> NEVER MARRIED<br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                          |                          | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |      | MD   |   |  |  |  |  |   |  |  |
| VIRGINIA   |        |                                   | U.S.A.  |                   |                                   |   |                          |                          | MONTGOMERY  |  |      | MD   |   |  |  |  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH  |        |                                   | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  |                   |                                   | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)  |                          |                          | 12b. KIND OF BUSINESS<br>OR INDUSTRY  |  |      | 208397   |   |  |  |  |  |   |  |  |
| ROCKVILLE  |        |                                   | SUNDAY GRAVE Adventist HOSPITAL   |                   |                                   |   |                          |                          |   |  |      | 208397   |   |  |  |  |  |   |  |  |
| 13a. STATE   |        |                                   | 13b. COUNTY   |                   |                                   | 13c. CITY OR TOWN   |                          |                          | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |      | 13e. STREET ADDRESS  |   |  |  |  |  |   |  |  |
| MD   |        |                                   | Montgomery  |                   |                                   | POOLESVILLE   |                          |                          | YES   |  |      | 18120 JERUSALEM RD   |   |  |  |  |  |   |  |  |
| 14. FATHER'S NAME<br>FIRST   |        |                                   | MIDDLE  | LAST              | 15. MOTHER'S MAIDEN NAME<br>FIRST |   |                          | MIDDLE                   | LAST  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>NO |      |  | 17. INFORMANT<br>ADDRESS 19120 JERUSALEM RD<br>POOLESVILLE, MD                      |  |  |  |  |   |  |  |
|  |        |                                   |   | BURRIS            | MOLLEY                            |   |                          |                          |   | 16b. SOCIAL SECURITY NO.<br>223-24-1005                                    |      |  |   |  |  |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I DEATH WAS CAUSED BY:                              |        |                                   | IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |                   |                                   |   |                          |                          |   |  |      |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>AUTO                             |  |  |  |  |   |  |  |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a) stating the under-<br>lying cause last.                             |        |                                   |   |                   |                                   |   |                          |                          |   |  |      |  | INDEF   |  |  |  |  |   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |        |                                   |   |                   |                                   |   |                          |                          |   |  |      |  |   |  |  |  |  |   |  |  |
| 19a. DATE OF OPERATION   |        |                                   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |                   |                                   |   |                          |                          |   |  |      |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |   |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH |        |                                   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR   |                   |                                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |                          |                          |   |  |      | 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> |   |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)<br>Home |  |  | 21f. LOCATION<br>STREET<br>18120 JERUSALEM RD<br>CITY OR TOWN<br>POOLESVILLE<br>COUNTY<br>Montgomery<br>STATE<br>MD |  |  |
|  |        |                                   | 0900 A.M. 10 9 1985   |                   |                                   | Complained of CHEST PAIN  |                          |                          |   |  |      |  |   |  |  |  |  |   |  |  |
| 22a. I certify that I took charge of the remains described above, held an  |        |                                   | Autopsy <input type="checkbox"/>  |                   |                                   | Inspection <input type="checkbox"/>   |                          |                          | Inquiry <input type="checkbox"/>  |  |      | and in my opinion  |   |  |  |  |  |   |  |  |
| death resulted from: Natural causes <input checked="" type="checkbox"/>  |        |                                   | Accident <input type="checkbox"/>   |                   |                                   | Suicide <input type="checkbox"/>  |                          |                          | Homicide <input type="checkbox"/>   |  |      | Undetermined manner <input type="checkbox"/>   |   |  |  |  |  |   |  |  |
| ACTUAL<br>SIGNATURE  |        |                                   | TITLE (SPECIFY)<br>M.D. Dr. Francis C. Mayle<br>MEDICAL EXAMINER  |                   |                                   |   |                          |                          |   |  |      |  |   |  | DATE<br>SIGNED 10/9/85   |  |  |   |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |        |                                   | ADDRESS 300 Wisconsin Ave Bethesda MD 20814   |                   |                                   |   |                          |                          |   |  |      |  |   |  | 20814  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |        |                                   | 23b. DATE<br>10/14/85   |                   |                                   | 23c. NAME OF CEMETERY OR CREMATORY<br>BLACK LICK  |                          |                          | 23d. LOCATION<br>CITY OR TOWN<br>RURAL RETREAT WYTHE VA   |  |      | 23e. COUNTY<br>STATE   |   |  |  |  |  |   |  |  |
| BURIAL   |        |                                   |   |                   |                                   | 23f. ADDRESS<br>22111 BEALLSVILLE RD.   |                          |                          | 23g. DATE REC'D. BY REGISTRAR<br>OCT 18 1985  |  |      | 23h. REGISTRAR'S SIGNATURE<br>John Truitt  |   |  |  |  |  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>W.C. HILTON  |        |                                   |   |                   |                                   | BARNESVILLE, MD   |                          |                          |   |  |      |  |   |  |  |  |  |   |  |  |
|  |        |                                   |   |                   |                                   |   |                          |                          |   |  |      |  |   |  |  |  |  |   |  |  |



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

|   |         |   |  |  |  |  |  |   |  |  |   |  |          |                            |  |
|---|---------|---|--|--|--|--|--|---|--|--|---|--|----------|----------------------------|--|
| 1 - STATE REGISTRAR   |         | REG. NO.  |  |  |  |  |  |   |  |  |   |  |          |                            |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |         | FIRST   |  |  | MIDDLE   |  |  | LAST  |  |  | 2a. DATE KNOWN<br>OF<br>ESTI-<br>DEATH<br>MATED |  | 2b. HOUR |                            |  |
| Robert  |         | C.  |  |  | Burriss  |  |  |   |  |  | <input checked="" type="checkbox"/> 10-30 1985  |  | M        |                            |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH<br>MONTH DAY YEAR  |  |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY   |  |  | IF UNDER 1 YR.  |  | IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN.                         |   | 2c. DATE<br>PRONOUNCED<br>DEAD                                 |          | 2d. HOUR<br>MONTH DAY YEAR |  |
| MALE  | WHITE   | AUG. 30, 1961   |  |  | 24 yrs.  |  |  |   |  |  |   | 10-30 1985   |          | 9:55 p.m.                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD.  |         | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  |  |  |  |  | MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>              |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County, MD. |          |                            |  |
| 10. CITY OR TOWN OF DEATH<br>Gaithersburg   |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Rt. 355 & Watkins Mill Road                                       |  |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)<br>PROJECT MANAGER             |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY<br>CONSTRUCTION               |   |  |          |                            |  |
| 13a. STATE<br>MD.   |         | 13b. COUNTY<br>MONT.  |  |  | 13c. CITY OR TOWN<br>GAIHTERSBURG  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>N. SUMMIT AVE. 20877                        |   |  |          |                            |  |
| 14. FATHER'S NAME<br>CARL   |         | E. BURRISS  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>MARY HELEN MORRIS   |  |  |   |  |          |                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>YES  |         | 16b. SOCIAL SECURITY NO.<br>1983-1984   |  |  | 17. INFORMANT<br>MAR Y HELEN Morris  |  |  | ADDRESS 20225 Lea Pond PI.<br>Gaithersburg, Md.   |  |  |   |  |          |                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>8120  |         | IMMEDIATE CAUSE (a) <b>Multiple Injuries</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. |  |  |  |  |  | 20879<br>APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH  |  |  |   |  |          |                            |  |
|   |         | { (b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |  |  |  |  |   |  |  |   |  |          |                            |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).   |         |   |  |  |  |  |  |   |  |  |   |  |          |                            |  |
| 19a. DATE OF OPERATION  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |  |  |   |  |          |                            |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         | 21b. TIME OF INJURY<br>HOUR XX:XX MONTH DAY YEAR<br>9:45P.M. 10-30 1985   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>driver of auto lost control and was struck by another vehicle |  |  |   |  |  |   |  |          |                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK AT WORK   |         | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)<br>road  |  |  | 21f. LOCATION<br>STREET<br>Rt. 355 & Watkins Mill Rd., Gaithersburg, Mont<br>CITY OR TOWN<br>gomery County, MD.<br>and in my opinion           |  |  |   |  |  |   |  |          |                            |  |
| 22a. I certify that I took charge of the remains described above, held an<br>death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/>  |  |  |  |  |  |   |  |  |   |  |          |                            |  |
| ACTUAL<br>SIGNATURE<br><i>Margarita Korell</i>  |         | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER  |  |  |  |  |  | DATE<br>SIGNED 10-31-85   |  |  |   |  |          |                            |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)  |         | Margarita A. Korell, M.D.   |  |  | ADDRESS<br>111 Penn St., Balto., Md. 21201   |  |  |   |  |  |   |  |          |                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>CREMATION  |         | 23b. DATE<br>OCT. 31, 1985  |  |  | 23c. NAME OF CEMETERY OR CREMATORIAL<br>Balt. Wash. Crematory  |  |  | 23d. LOCATION<br>CITY OR TOWN<br>Laurel P. George Maryland                                      |  |  |   |  |          |                            |  |
| 24. FUNERAL DIRECTOR<br>FRANCIS H. BARBER   |         | LAYTONSVILLE, MD. 20879   |  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 04 1985   |  |  | REGISTRAR'S SIGNATURE<br><i>J. George</i>   |  |  |   |  |          |                            |  |
| BP  |         |   |  |  |  |  |  |   |  |  |   |  |          |                            |  |
| DHMH - 17<br>(VR A15 ME (5))  |         |   |  |  |  |  |  |   |  |  |   |  |          |                            |  |

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS OF DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. PRINT NAME OF MEDICAL EXAMINER ALONG WITH ADDRESS. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH A TELEGRAM. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MD. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |  |   |  |   |   |  |  |   |       |  | REG. NO. 2841   |          |  |
|---|--|--|---|--|---|---|--|--|---|-------|--|---|----------|--|
| 1- STATE REGISTRAR  |  |  |   |  |   |   |  |  |   |       |  |   |          |  |
| I. DECEASED NAME<br>(TYPE OR PRINT)   |  |  | FIRST   | MIDDLE                                       | LAST  | 2a DATE KNOWN X<br>OF ESTI-<br>MATED <input type="checkbox"/>   |  |  | MONTH   | DAY   | YEAR   | 2b. HOUR  |          |  |
| Roland Leslie Burruss   |  |  |   |  |   | 9/27/1985   |  |  |   |       |  | 7:55 P.M.   |          |  |
| 3 SEX: Male   |  | 4 RACE: White                                      | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>Oct. 21, 1965  | 6 AGE (IN YEARS<br>LAST BIRTHDAY)<br>19 YRS. | 7 IF UNDER 1 YR.<br>MONTHS DAYS   | 8 IF UNDER 24 HRS.<br>HOURS MIN   | 2c DATE<br>PRONOUNCED<br>DEAD<br>9/27/1985 |  |   | MONTH | DAY  | YEAR  | 2d. HOUR |  |
| 7a BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.             |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County, MD. |   |       |  |   |          |  |
| II. CITY OR TOWN OF DEATH<br>Silver Spring  |  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Holy Cross Hospital |  |   |   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)<br>Carpenter                   |       |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY<br>Construction                                |          |  |
| 13a. STATE<br>Florida   |  |  | 13b. COUNTY<br>Lee  |  |   | 14. CITY OR TOWN<br>N. Ft. Myers  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |       | 13e. STREET ADDRESS<br>3234 Carrington Dr. 99999 |   |          |  |
| 14. FATHER'S NAME<br>First: Bernard   |  |  | Middle: Nelson  |  |   | Last: Burruss   |  |  | 15. MOTHER'S MAIDEN NAME<br>First: Betty  |       |  | Middle: Louise  |          |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No  |  |  | 16b. SOCIAL SECURITY NO.<br>228-06-8919   |  |   | 17. INFORMANT<br>Bernard Burruss  |  |  | 18. APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |       |  |   |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><br>8161 IMMEDIATE CAUSE (a) _____<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a) stating the under-<br>lying cause last. }<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF  |  |  |   |  |   |   |  |  |   |       |  |   |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |  |   |  |   |   |  |  |   |       |  |   |          |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |   |  |  |   |       |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |          |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |  | 21b. TIME OF INJURY<br>HOUR <input checked="" type="checkbox"/> MONTH DAY YEAR<br>7:10 M. 9/27/1985                               |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>passenger on motorcycle/lost control/ejected |  |  |   |       |  |   |          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK  |  |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)<br>roadway   |  |   | 21f. LOCATION<br>STREET<br>Rt. 495, Westbound Linden Lane, Montg., Md.  |  |  | CITY OR TOWN<br>COUNTY<br>STATE   |       |  |   |          |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion<br>death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |   |  |   |   |  |  |   |       |  |   |          |  |
| ACTUAL<br>SIGNATURE<br><i>Margarita Korell</i>  |  | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER |   |  |   |   |  |  |   |       |  |   |          |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)  |  | ADDRESS<br>111 Penn St.                            |   |  |   |   |  |  |   |       |  |   |          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |  | 23b. DATE<br>Oct. 2, 1985   |  |   | 23c. NAME OF CEMETERY OR CREMATORIAL<br>Asbury Cemetery   |  |  | 23d. LOCATION<br>CITY OR TOWN<br>Moorefield   |       |  | COUNTY<br>Hardy   |          |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Arnold-Basagic Funeral Home, Petersburg, W.Va.  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 23 1985  |  |   | 25b. REGISTRAR'S SIGNATURE<br><i>Arnold Basagic</i>   |  |  |   |       |  |   |          |  |
| DHMH - 17<br>(VR A15 ME (5))  |  |  |   |  |   |   |  |  |   |       |  |   |          |  |

010863

3040512

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

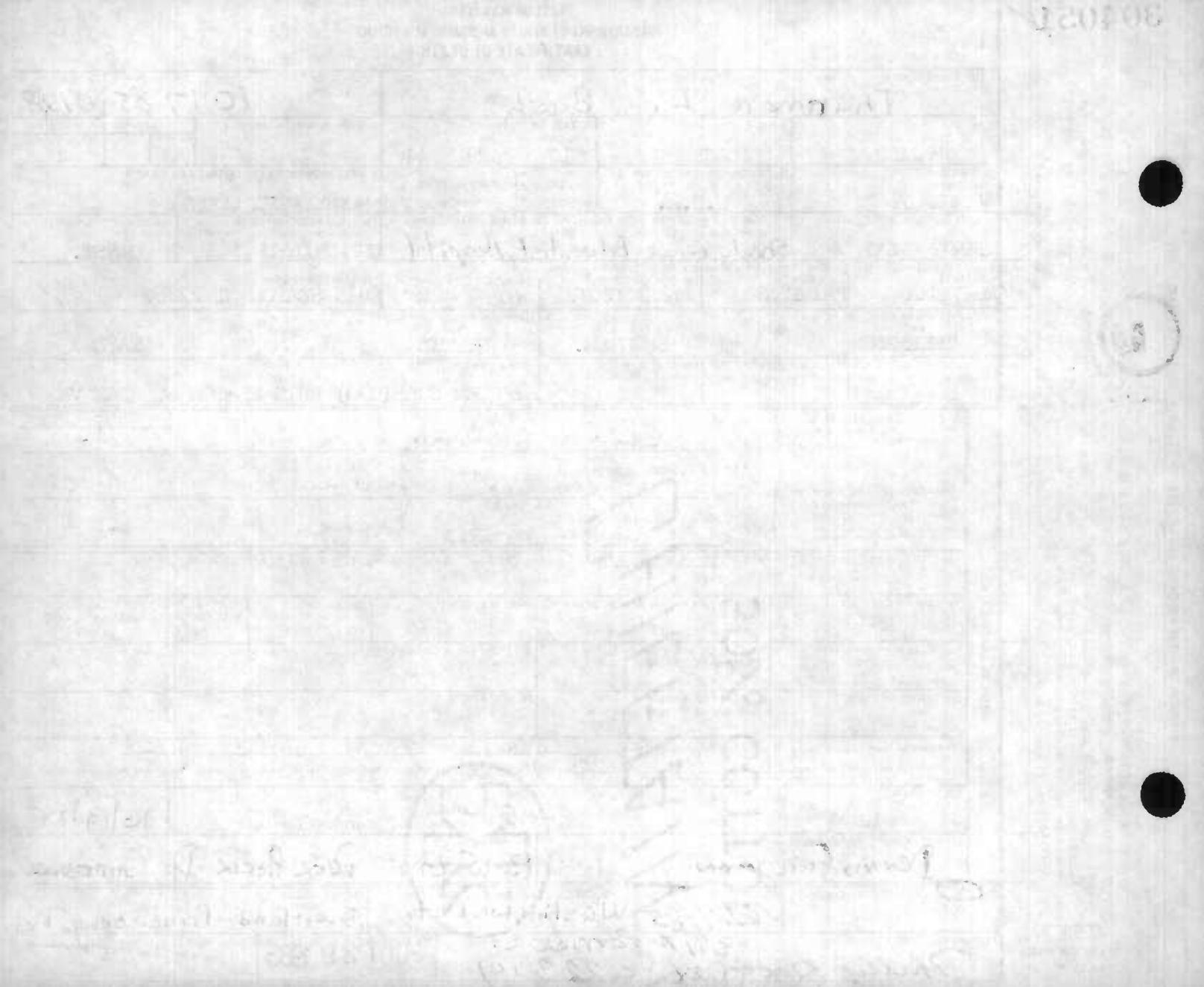
85 28972

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |   |        |   |   |   |   |  |   |  |       |  |
|---|--|---|--------|---|---|---|---|--|---|--|-------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   | FIRST  | MIDDLE  | LAST  | 2a. DATE OF DEATH   | MONTH   | DAY  | YEAR  | 2b. HOUR   |       |  |
| Thurman L. Bush   |  |   |        |   |   | 10 17 85  |   |  |   | 0128M  |       |  |
| 3. SEX  |  | 4. RACE   |        | 5. DATE OF BIRTH  |   |   | 6. AGE (IN YEARS LAST BIRTHDAY)   |  |   | 7b. HOUR   |       |  |
| MALE  |  | BLACK   |        | MONTH<br>10   | DAY<br>29   | YEAR<br>44  | 40 YRS.   |  |   | IF UNDER 1 YEAR<br>MONTHS DAYS                                   |       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |   |   | 9. BALTIMORE CITY OR COUNTY OF DEATH                                      |  |   | 12b. KIND OF BUSINESS OR INDUSTRY                                |       |  |
| VIRGINIA  |  | U.S.A.  |        | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                    |   |   | MONTGOMERY COUNTY MD.   |  |   | CONST.   |       |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |        |   |   |   |   |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |       |  |
| SHADY GROVE   |  | Shady Grove Adventist Hospital.   |        |   |   |   |   |  |   | UNEMPLOYED   |       |  |
| 13a. STATE  |  | 13b. COUNTY   |        | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  | 13e. STREET ADDRESS   |  |       |  |
| VIRGINIA  |  | FAIRFAX   |        | ALEXANDRIA  |   |   |   |  | 8015 SEATON ST 22306 99494  |  |       |  |
| 14. FATHER'S NAME   |  | FIRST<br>THURMAN  | MIDDLE | LAST<br>BUSH SR.  | 15. MOTHER'S MAIDEN NAME  |   |   | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) NO |   | 16b. SOCIAL SECURITY NO.   |       |  |
|   |  |   |        |   | NETTIE M  |   |   |  |   | 17. INFORMANT  |       |  |
|   |  |   |        |   |   |   |   |  |   | STEPHEN BUSH (BRO) 8015 SEATON ST ALEX VA                        |       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 18a, b, and c.)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardiogenic shock</i> APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause lost. } 12 hrs<br>(b) <i>Myocardial infarction</i><br>(c) <i>Congestive heart Disease</i> 18 hrs |  |   |        |   |   |   |   |  |   |  |       |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.  |  |   |        |   |   |   |   |  |   |  |       |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |        |   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |        |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |  |   |  |       |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |        |   | 21f. LOCATION<br>STREET   |   | CITY OR TOWN  |  | COUNTY  |  | STATE |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>10/16</i> , 19 <i>85</i> , to <i>10/17</i> , 19 <i>85</i> , that (I) (we) last<br>saw the deceased alive on <i>10/17</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) did (did not) view the body after death.                                       |  |   |        |   |   |   |   |  |   |  |       |  |
| 22b. SIGNATURE<br><i>Douglas</i>  |  | 22c. DEGREE<br><i>MD</i>  |        |   | ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |   | 22d. DATE SIGNED<br><i>10/17/85</i>                                    |   |  |       |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Dennis Friedman</i>   |  | 22f. ADDRESS<br><i>13-15 East Deer Park Dr, Gaithersburg</i>  |        |   |   |   |   |  |   |  |       |  |
| 23a. CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE<br><i>10/21/85</i>  |        | 23c. NAME OF CEMETERY OR CREMATORIAL<br><i>Washington Nat.</i>                        |   |   | 23d. LOCATION<br>CITY OR TOWN<br><i>Suitland</i>                          |  | COUNTY<br><i>Prince George Md.</i>  |  | STATE |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Philip Bell</i>  |  | ADDRESS<br><i>311 N Patrick St<br/>Ave Va 22314</i>   |        |   | 25a. DATE REC'D. BY REGISTRAR<br><i>OCT 29 1985</i>   |   |   | 25b. REGISTRAR'S SIGNATURE<br><i>John J. P. Bell</i>                   |   |  |       |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be given to the attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached from patient's record and removed.  
IMPORTANT: If item 21a is marked or Item 18 shows any injury, or other unusual event, the medical examiner should be notified.



8 5 2 8 9 7 3

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

305093

1 - STATE REGISTRAR

REG. NO.

|  |                             |   |  |                                  |   |   |  |  |   |               |
|--|-----------------------------|---|--|----------------------------------|---|---|--|--|---|---------------|
| 1 DECEASED NAME<br><small>(TYPE OR PRINT)</small>  |                             |   | FIRST  | MIDDLE                           | LAST  | 2a. DATE OF DEATH   | MONTH  | DAY  | YEAR  | 2b. HOUR      |
| <b>RICHARD B. BUTLER</b>   |                             |   |  |                                  |   | <b>10/25/85</b>   |  |  |   | <b>4 56 M</b> |
| 3 SEX  | 4 RACE                      | 5. DATE OF BIRTH  |  |                                  | 6 AGE (IN YEARS LAST BIRTHDAY)  | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS  |   |               |
| <b>m.</b>  | <b>B</b>                    | MONTH   | DAY  | YEAR                             | <b>38</b>   | MONTHS  | DAYS   | HOURS  | MIN.  |               |
| 7a BIRTHPLACE<br><small>(STATE OR FOREIGN)</small>   | 7b CITIZEN OF WHAT COUNTRY? | 8   |  |                                  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |   |  |  |   |               |
| <b>WASHINGTON, D.C.</b>  | <b>U.S.A.</b>               | MARRIED <input checked="" type="checkbox"/>   | NEVER MARRIED <input type="checkbox"/>   | WIDOWED <input type="checkbox"/> | DIVORCED <input type="checkbox"/>   | <b>MONTGOMERY</b>   |  |  |   |               |
| 10. CITY OR TOWN OF DEATH  |                             |   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><small>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)</small> |                                  |   | 12a. USUAL OCCUPATION   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |               |
| <b>SILVERSPRINGS</b>   |                             |   | <b>HOLY CROSS</b>  |                                  |   | <b>METRO CLAIM REPRESENTATIVE-TRANSPORTATION</b>                    |  |  | <b>METRO</b>  |               |
| 13a. STATE<br><small>MD</small>  |                             |   | 13c. CITY OR TOWN  |                                  |   | 13d. INSIDE CITY LIMITS?  |  |  | 13e. STREET ADDRESS / ZIP CODE                                      |               |
| <b>MARYLAND</b>  |                             |   | <b>PRINCE GEORGE'S MARLBORO</b>  |                                  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  | <b>9214 CROCKETT PL. 20772</b>                                      |               |
| 14. FATHER'S NAME  |                             |   | 15. MOTHER'S MAIDEN NAME   |                                  |   |   |  |  |   |               |
| FIRST  | MIDDLE                      | LAST  | FIRST  | MIDDLE                           | LAST  |   |  |  |   |               |
| <b>JOHN</b>  | <b>C.</b>                   | <b>BUTLER</b>   | <b>JEAN</b>  |                                  | <b>CANNADAY</b>   |   |  |  |   |               |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br><small>(YES, NO OR UNKNOWN)</small>  |                             |   | 16b. SOCIAL SECURITY NO.   |                                  |   | 17. INFORMANT   |  |  | ADDRESS   |               |
| YES  |                             |   | 579-58-6805  |                                  |   | (wife)  |  |  | 9214 CROCKETT PL.<br>BERNADETTE M. BUTLER- UPPER MARLBORO, MD 20772 |               |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, b1, and c1)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b>   |                             |   |  |                                  |   |   |  |  |   |               |
| DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Atrial fibrillation</b>   |                             |   |  |                                  |   |   |  |  |   |               |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Idiopathic Dilated Cardiomyopathy</b> 1 year  |                             |   |  |                                  |   |   |  |  |   |               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a<br><b>Diabetes Mellitus</b>   |                             |   |  |                                  |   |   |  |  |   |               |
| 19a. DATE OF OPERATION   |                             | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |                                  |   |   | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |               |
|  |                             |   |  |                                  |   |   | YES <input type="checkbox"/> NO <input type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |               |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br><small>(IF EITHER, NOTIFY MEDICAL EXAMINER)</small>  |                             | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                    |  |                                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)   |   |  |  |   |               |
| 21d. INJURY OCCURRED<br><small>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></small>   |                             | 21e. PLACE OF INJURY<br><small>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)</small>         |  |                                  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |   |               |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/16/85</b> , to <b>10/25/85</b> , that (II) (we) last saw the deceased alive on <b>10/23/85</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. |                             |   |  |                                  |   |   |  |  |   |               |
| 22b. SIGNATURE<br><b>Herman S. Segal MD</b>  |                             | 22c. DEGREE   |  |                                  | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  |  |   |               |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Herman B. Segal</b>  |                             | 22e. ADDRESS<br><b>10513 Georgia Ave<br/>Silver Spring Md</b>                                 |  |                                  |   |   |  |  |   |               |
| 23a. BURIAL, CREMATION, REMOVAL<br><small>(SPECIFY)</small>  |                             | 23b. DATE<br><b>BURIAL OCT. 30, 1985</b>  |  |                                  | 23c. NAME OF CEMETERY OR CREMATORIUM<br><b>SURRECTION CEMETERY</b>  |   |  | 23d. LOCATION<br>CITY OR TOWN <b>CLINTON</b> COUNTY <b>PRINCE GEORGE'S, MD</b> STATE |   |               |
| 24. FUNERAL DIRECTOR<br><small>NAME</small>  |                             | 24b. ADDRESS<br><b>LEE FUNERAL HOME, INC. 6633 OLD ALEXANDER FERRY RD., CLINTON, MD 20735</b> |  |                                  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 30 1985</b>   |   |  | 25b. REGISTRAR'S SIGNATURE   |   |               |

executed within 24 hours after death. Page 4 may be

and completely filled in by the funeral director. Page 3  
should be detached for use as the burial-transit permit. Then please remove it from page 1 and attach it to the burial permit  
with the State Dept. of Health and Mental Hygiene prior to burial or cremation.

**IMPORTANT:** If item 18 is marked or item 21 shows any injury, or other traumatic event, the medical examiner will be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the attending physician retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove it from page 1 and attach it to the burial permit with the State Dept. of Health and Mental Hygiene prior to burial or cremation.

DHMH - 16 60M 7/84  
(VRA 15. 4)

338206



298071

85 28914

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |              |   |                     |  |  |                    |  |  |      |   |   |
|---|--------------|---|---------------------|--|--|--------------------|--|--|------|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |              |   | FIRST               | MIDDLE   | LAST   | 20. DATE OF DEATH  | MONTH  | DAY  | YEAR | 21. HOUR  |   |
| <i>Vivian H. Byrd</i>   |              |   |                     |  | <i>Byrd</i>  | <i>10/19/85</i>    |  |  |      | <i>8:10 AM</i>  |   |
| 3. SEX  | 4. RACE      | 5. DATE OF BIRTH  |                     |  | 6. AGE (IN YEARS LAST BIRTHDAY)  | 7. IF UNDER 1 YEAR | 8. IF UNDER 24 MRS.  |  |      | 9. IF UNDER 24 MRS.                                       |   |
| <i>female</i>   | <i>White</i> | MONTH   | DAY                 | YEAR   | <i>69</i>  | MONTHS             | DAYS   | MONTHS   | DAYS | YRS   |   |
| 7a. BIRTHPLACE<br>COUNTRY   |              | 7b. CITIZEN OF WHAT COUNTRY?  |                     |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>  |                    | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Montgomery</i> |   |
| <i>VA.</i>  |              | <i>U.S.A.</i>   |                     |  |  |                    |  |  |      | MD.   |   |
| 10. CITY OR TOWN OF DEATH<br><i>Silver Spring</i>   |              | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Holy Cross Hospital</i> |                     |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Homemaker</i>   |                    |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>AT HOME</i>  |      |   |   |
| 13a. STATE<br><i>MD</i>   |              | 13c. CITY OR TOWN<br><i>PR. GEORGE TAKOMA PARK</i>  |                     |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                    |  | 13e. STREET ADDRESS / ZIP CODE<br><i>7200 13th Place 20912</i>   |      |   |   |
| 14. FATHER'S NAME<br>FIRST<br><i>ANTHONY</i>  |              | MIDDLE<br><i>JOSEPH</i>   | LAST<br><i>HART</i> | 15. MOTHER'S MAIDEN NAME<br>FIRST<br><i>FANNIE MAE</i> |  |                    | MIDDLE   |  |      | LAST<br><i>MILLER</i>                                     |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>   |              | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><i>219-34-9322</i>   |                     |  | 17. INFORMANT<br><i>LAWRENCE H. BYRD, 1021 CRANBROOK AVE Rockville, MD</i>   |                    |  | ADDRESS  |      |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c.)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><i>Respiratory failure</i>  |              |   |                     |  |  |                    |  |  |      |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br><i>Chronic obstructive pulmonary disease</i>   |              |   |                     |  |  |                    |  |  |      |   |   |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |              |   |                     |  |  |                    |  |  |      |   |   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a<br><i>Congestive heart failure</i>  |              |   |                     |  |  |                    |  |  |      |   |   |
| 19a. DATE OF OPERATION  |              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                     |  | 20a. AUTOPSY?  |                    |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |      |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |              | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                    |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |      |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>   |              | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                     |  | 21f. LOCATION<br>STREET<br><i>82</i>   |                    |  | CITY OR TOWN<br><i>10-19</i>   |      |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>10-18</i> 19 <i>85</i> , to <i>10-19</i> 19 <i>85</i> . that (I) (we) last<br>saw the deceased alive on <i>10-18</i> 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I/we) did not know the body after death. |              |   |                     |  |  |                    |  |  |      |   | 22b. DATE SIGNED<br><i>10-19-85</i>             |
| 22c. SIGNATURE<br><i>Carroll O. Murphy</i>  |              | 22d. DEGREE<br><i>940</i>   |                     |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                    |  |  |      |   |   |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)   |              | 22f. ADDRESS  |                     |  |  |                    |  |  |      |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |              | 23b. DATE<br><i>Oct. 22 1985</i>  |                     |  | 23c. NAME OF CEMETERY OR CREMATORIAL<br><i>Manassas Cemetery</i>   |                    |  | 23d. LOCATION<br>CITY OR TOWN<br><i>Manassas</i>   |      |   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Takoma Funeral Home Inc.</i>   |              | ADDRESS<br><i>301 Carroll Dr. N.W. DC</i>   |                     |  | 25a. DATE REC'D. BY REGISTRAR<br><i>Oct. 22 1985</i>   |                    |  | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Murphy</i>  |      |   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be submitted to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and certified, it should be forwarded to the funeral director. Then please remove carbon copies. Please do not file until after death. Form 3 may be used.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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*Cleared by Dr. [Signature]*

294030

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

35 28915

REG. NO.

|  |  |  |   |                     |   |  |   |  |  |   |
|--|--|--|---|---------------------|---|--|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  | FIRST<br><i>James</i>   | MIDDLE<br><i>A.</i> | LAST<br><i>CANAVAN</i>  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>10 14 85</i>                                       | MONTH<br><i>OCT</i>   | DAY<br><i>14</i>   | YEAR<br><i>85</i>                            | 2b. HOUR<br>IF UNDER 12 HRS.<br><i>12 16 AM</i> |
| 3. SEX<br><i>MALE</i>  |  |  | 4. RACE<br><i>WHITE</i>   |                     | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>1 29 17</i>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>IF UNDER 1 YEAR<br><i>68</i><br>MONTHS DAYS<br><i>0 0</i> |   |  | IF UNDER 24 HRS.<br>HOURS MIN.<br><i>0 0</i> |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>IRELAND</i>  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |                     | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>MONTGOMERY</i>                                    |   |  | MD.  |   |
| 10. CITY OR TOWN OF DEATH<br><i>SILVER SPRING</i>  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Holy Cross HOSPITAL</i> |                     | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>PLASTERER</i>  |  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |
| 13a. STATE<br><i>MARYLAND</i>  |  |  | 13b. COUNTY<br><i>MONTGOMERY</i>  |                     | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   | 13e. STREET ADDRESS / ZIP CODE<br><i>2200 HENDERSON AVENUE 20902</i>   |  |   |
| 14. FATHER'S NAME<br>FIRST<br><i>JAMES</i>   |  |  | MIDDLE<br><i>CANAVAN</i>  | LAST                | 15. MOTHER'S MAIDEN NAME<br>FIRST<br><i>MARY</i>  |  |   | MIDDLE<br><i>CHAMBERS</i>  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES OR NO OR UNKNOWN)<br><i>NO</i>  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><i>577-09-7188</i>   |                     | 17. INFORMANT<br><i>ANN NICHOLSON</i>   |  |   | ADDRESS<br><i>SAME AS 13</i>   |  |   |
| 18. CAUSE OF DEATH (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><i>Metastatic Bronchogenic Carcinoma</i>  |  |  |   |                     |   |  |   |  |  |   |
| APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><i>1 month</i>  |  |  |   |                     |   |  |   |  |  |   |
| DUE TO, OR AS A CONSEQUENCE OF<br>{<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause lost.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |  |   |                     |   |  |   |  |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |   |                     |   |  |   |  |  |   |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                     |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                     | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |   |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                     | 21f. LOCATION<br>STREET   |  |   | CITY OR TOWN   | COUNTY                                       | STATE   |
| 22a. I certify that (i) this hospital attended the deceased from<br>now till his/her death on <i>10 Oct 85</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I/we did/did not view the body after death.) |  |  |   |                     |   |  |   |  |  | 19. <i>85</i> to <i>Oct 14 85</i> 0             |
| 22b. SIGNATURE<br><i>[Signature]</i>   |  |  |   |                     |   |  |   |  |  | DEGREE  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  | 22e. ADDRESS<br><i>Michael L. Barth, MD</i>   |                     |   |  |   |  |  | 22f. DATE SIGNED<br><i>14 Oct 85</i>            |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>BURIAL</i>  |  |  | 23b. DATE<br><i>10/16/85</i>  |                     | 23c. NAME OF CEMETERY OR CREMATORIAL<br>GATE OF HEAVEN  |  |   | 23d. LOCATION<br>CITY OR TOWN<br><i>SILVER SPRING</i>  |  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>FRANCIS J. COLLINS, JR.</i>   |  |  | 25a. DATE REC'D. BY REGISTRAR<br><i>OCT 17 1985</i>   |                     | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |   |  |  |   |
| DHMH - 16 60M 7/84<br>(VRA 15, 4)  |  |  |   |                     |   |  |   |  |  |   |

and a small child

and a small child

and a small child

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and returned to you, it should be detached for use as the burial transcript. Then please remove carbon copy. Pages 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical certificate must be completed.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |        |  |                                      |  |   |                 |        | 8 5 2 8 9 7 6  |  |       |  |                                     |                         |                        |  |
|---|--|---|--|---|--------|--|--------------------------------------|--|---|-----------------|--------|--|--|-------|--|-------------------------------------|-------------------------|------------------------|--|
|   |  |   |  |   |        |  |                                      |  |   |                 |        | REG. NO.   |  |       |  |                                     |                         |                        |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   | FIRST  | MIDDLE  | LAST   | 2a. DATE OF DEATH  |                                      |  | MONTH   | DAY             | YEAR   | 2b. HOUR am<br>2:00 m  |  |       |  |                                     |                         |                        |  |
| Samuel R. Carter Sr.  |  |   |  |   |        | October 7, 1985  |                                      |  |   |                 |        |  |  |       |  |                                     |                         |                        |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |        |  | 6. AGE (IN YEARS LAST BIRTHDAY)      |  |   | IF UNDER 1 YEAR |        | IF UNDER 24 HRS  |  |       |  |                                     |                         |                        |  |
| Male  |  | Caucasian   |  | February 11, 1924   |        |  | 61                                   |  |   | YRS             | MONTHS | DAYS   | HOURS  | MIN.  |  |                                     |                         |                        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |        |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |   |                 |        |  |  |       |  |                                     |                         |                        |  |
| Virginia  |  | United States   |  |   |        |  | Montgomery County                    |  |   |                 |        |  |  |       |  |                                     |                         |                        |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |        |  | 12b. KIND OF BUSINESS OR INDUSTRY    |  |   |                 |        |  |  |       |  |                                     |                         |                        |  |
| Germantown  |  | 11420 Floweron Place  |  | Asst. Manager   |        |  | Retail Food                          |  |   |                 |        |  |  |       |  |                                     |                         |                        |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |   |        |  |                                      |  |   |                 |        |  |  |       |  |                                     |                         |                        |  |
| 13a. STATE  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |        | 13d. INSIDE CITY LIMITS?   |                                      |  | 13e. STREET ADDRESS / ZIP CODE                                      |                 |        |  |  |       |  |                                     |                         |                        |  |
| Maryland  |  | Montgomery  |  | Germantown  |        | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                                      |  | 11420 Floweron Place 20874  |                 |        |  |  |       |  |                                     |                         |                        |  |
| 14. FATHER'S NAME   |  |   | FIRST  | MIDDLE  | LAST   | 15. MOTHER'S MAIDEN NAME   |                                      |  | FIRST   | MIDDLE          | LAST   |  |  |       |  |                                     |                         |                        |  |
| Clifton   |  |   | W.   |   | Carter | Charlotte  |                                      |  | R.  |                 | Sharpe |  |  |       |  |                                     |                         |                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)                |   |        | 17. INFORMANT (Wife)   |                                      |  | ADDRESS   |                 |        |  |  |       |  |                                     |                         |                        |  |
| Yes   |  |   | WWII   |   |        | Dorothy G. Carter  |                                      |  | 11420 Floweron Pl.<br>Germantown, Maryland                          |                 |        |  |  |       |  |                                     |                         |                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c)<br>PART I. DEATH WAS CAUSED BY:   |  |   |  |   |        |  |                                      |  |   |                 |        | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                |  |       |  |                                     |                         |                        |  |
| IMMEDIATE CAUSE (a) <i>Cardiovascular arrest</i>  |  |   |  |   |        |  |                                      |  |   |                 |        |  |  |       |  |                                     |                         |                        |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Myocardial Spasms</i>  |  |   |  |   |        |  |                                      |  |   |                 |        |  |  |       |  |                                     |                         |                        |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>Cardiac Depressing Drugs</i>   |  |   |  |   |        |  |                                      |  |   |                 |        |  |  |       |  |                                     |                         |                        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><i>Hypertension, Congestive Heart Failure</i>   |  |   |  |   |        |  |                                      |  |   |                 |        |  |  |       |  |                                     |                         |                        |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |        | 20a. AUTOPSY?  |                                      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |                 |        |  |  |       |  |                                     |                         |                        |  |
|   |  |   |  |   |        | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                                      |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                 |        |  |  |       |  |                                     |                         |                        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                      |  |   |                 |        |  |  |       |  |                                     |                         |                        |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |        | 21f. LOCATION<br>STREET  |                                      |  | CITY OR TOWN  |                 |        | COUNTY   |  | STATE |  |                                     |                         |                        |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>12/17 1984</i> to <i>12/17 1984</i> , that (I) (we) last saw the deceased alive on <i>12/23 1984</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. |  |   |  |   |        |  |                                      |  |   |                 |        |  |  |       |  |                                     |                         |                        |  |
| 22b. SIGNATURE<br><i>Douglas R. Shumaker, M.D.</i>  |  |   |  |   |        |  |                                      |  |   |                 |        | DEGREE   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |       |  | 22c. DATE SIGNED<br><i>10/17/85</i> |                         |                        |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   | 22e. ADDRESS   |   |        | 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)                                   |                                      |  | 23b. DATE 1985<br>Burial October 9,                                 |                 |        | 23c. NAME OF CEMETERY OR CREMATORIAL<br>Parklawn Memorial Park |  |       | 23d. LOCATION<br>CITY OR TOWN<br>Rockville |                                     | 23e. COUNTY<br>Maryland | 23f. STATE<br>Maryland |  |
| Douglas R. Shumaker, M.D.   |  |   | 615 W. Montgomery Ave. Rockville, Md 20850                             |   |        |  |                                      |  |   |                 |        |  |  |       |  |                                     |                         |                        |  |
| 24. FUNERAL DIRECTOR<br>P.A. <i>Robert A. Pumphrey Funeral Homes,<br/>7557 Wisconsin Avenue, Bethesda, Maryland</i>   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><i>OCT 10 1985</i>                    |   |        | 25b. REGISTRAR'S SIGNATURE<br><i>J. Pendell</i>                                |                                      |  |   |                 |        |  |  |       |  |                                     |                         |                        |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that death certificate be executed within 24 hours after death, and may be reponed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then attach pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene under the burial, cremation or removal.

IMPORTANT: If item 21 is marked and item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

311137

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 28971

1 - STATE REGISTRAR

REG. NO.

|  |  |   |   |   |   |   |   |  |                                       |                                    |  |                  |
|--|--|---|---|---|---|---|---|--|---------------------------------------|------------------------------------|--|------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   | FIRST<br><b>SOPHIE</b>  | MIDDLE  | LAST<br><b>CHAITOVITZ</b>   | 20. DATE OF DEATH<br>MONTH<br><b>April</b>                | DAY<br><b>7, 1898</b>   | YEAR<br><b>1898</b>  | 26 HOUR<br><b>230 M</b>               |                                    |  |                  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Caucasian</b>   | 5. DATE OF BIRTH<br>MONTH<br><b>April</b>   |   |   | DAY<br><b>7</b>   | YEAR<br><b>1898</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>87</b>   | IF UNDER 1 YEAR<br>MONTHS<br><b>0</b> | IF UNDER 1 DAY<br>DAYS<br><b>0</b> | IF UNDER 24 HRS<br>HOURS<br><b>230</b> | MIN.<br><b>0</b> |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Russia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> |   |  |                                       |                                    |  |                  |
| 10. CITY OR TOWN OF DEATH<br><b>Rockville</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Hebrew Home of Greater Washington</b> |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>  |   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>   |                                       |                                    |  |                  |
| 13a. STATE<br><b>Maryalnd</b>  |  | 13b. COUNTY<br><b>Montgomery</b>  | 13c. CITY OR TOWN<br><b>Rockville</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |   | 13e. STREET ADDRESS / ZIP CODE<br><b>7112 Wolftree Lane 20843</b> |  |                                       |                                    |  |                  |
| 14. FATHER'S NAME<br>FIRST<br><b>Joseph</b>  |  | MIDDLE  | LAST<br><b>Spiberg</b>  | 15. MOTHER'S MAIDEN NAME<br>FIRST<br><b>Anna</b>  |   |   | MIDDLE  | LAST<br><b>Garfinkle</b>   |                                       |                                    |  |                  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>N/A</b>   |   |   | 17. INFORMANT<br><b>Samuel A. Chaitovitz</b>  |   |   | ADDRESS<br><b>same as #13</b>  |                                       |                                    |  |                  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>MULTI-INfarct DEMENTIA</b><br>APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |   |   |   |   |   |   |  |                                       |                                    |  |                  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CEREBRO-VASCULAR DISEASE</b>  |  |   |   |   |   |   |   |  |                                       |                                    |  |                  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ATHEROSCLEROSIS</b>   |  |   |   |   |   |   |   |  |                                       |                                    |  |                  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a<br><b>ATHEROSCLEROTIC CORONARY, ISCHEMIC HEART DISEASE</b>  |  |   |   |   |   |   |   |  |                                       |                                    |  |                  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?   |   |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                       |                                    |  |                  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)   |   |   |  |                                       |                                    |  |                  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>8/23/83</b>  |   |   | 21f. LOCATION<br>STREET<br><b>83</b>  |   |   | CITY OR TOWN<br><b>10/25/85</b>  | COUNTY                                | STATE                              |  |                  |
| 22a. I certify that (I) (we) attended the deceased from 8/23/83 to 10/25/85, that (I) (we) last saw the deceased alive on 10/25/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did/did not view the body after death. |  |   |   |   |   |   |   |  |                                       |                                    |  |                  |
| 22b. SIGNATURE<br><b>D.J. Patel</b>  |  | 22c. DEGREE<br><b>M.D.</b>  |   |   | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |   | 22e. DATE SIGNED<br><b>10/25/85</b>  |                                       |                                    |  |                  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>D.J. Patel</b>   |  | 22e. ADDRESS<br><b>6121 MONTROSE RD, Rockville, MD.</b>   |   |   |   |   |   |  |                                       |                                    |  |                  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>   |  | 23b. DATE<br><b>10-26-85</b>  |   | 23c. NAME OF CEMETERY OR CREMATORIAL<br><b>Metropolitan Crematory</b>                           |   |   | 23d. LOCATION<br>CITY OR TOWN<br><b>Alexandria, Va.</b>           |  | COUNTRY                               |                                    |  | STATE            |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Ives-Pearson Funeral Homes<br/>Falls Church, Va. 22046</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 31 1985</b>   |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>John D. Parker</b>   |   |   |  |                                       |                                    |  |                  |

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SERIALS SECTION



**NO HOSPITAL OR ATTENDING PHYSICIAN.** The  
reigned by the hospital or attending physician.

law requires that death penalty be executed within 24 hours after death. Page 4 may be

**H**O HOSPITAL OR ATTENDING PHYSICIAN. The law requires that health care must be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**H**OW TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please write death date and time on page 1 and 2. Please attach this paper to the death certificate with the State Dept. of Health and Mental Hygiene prior to burial or cremation.

**IMPORTANT:** If Item 21 is marked  Item 18 shows any injury or other traumatic event the medical examiner must be notified.

DHMH - 16 60M 7/8  
(VRA 15, 4)

**308041**

**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

8 5 2 8 9 / 8

REG. NO.

|  |  |  |  |   |   |
|--|--|--|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Toula N.M. Chipouras</b>   |  |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>10 29 85</b>  | 2b HOUR<br>IF UNDER 12 HRS.<br>MONTH DAYS HOURS MIN.<br><b>9:05 M</b> |   |
| 3 SEX<br><b>Female</b>   | 4 RACE<br><b>white</b>   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 15 08</b>  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b>  | 7b CITIZEN OF WHAT COUNTRY?<br><b>Sparta, Greece U.S.A.</b>           |   |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Sparta, Greece</b>  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery Co., MD.</b>  |  |   |   |
| 10 CITY OR TOWN OF DEATH<br><b>Sandy Spring</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Friends Nursing Home</b>                   | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>US Capitol</b>   | 12b KIND OF BUSINESS OR INDUSTRY<br><b>Hostess</b>   |   |   |
| 13a STATE<br><b>D.C.</b>   | 13c CITY OR TOWN<br><b>Wash.D.C.</b>   | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                     | 13e STREET ADDRESS / ZIP CODE<br><b>1517 Oates St.N.E. 20009</b>   |   |   |
| 14 FATHER'S NAME<br><b>Efthimios</b>   | MIDDLE<br><b>Gouzoulis</b>   | 15 MOTHER'S MAIDEN NAME<br><b>Aspasia</b>  | MIDDLE<br><b>Vasiliou</b>  |   |   |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>None</b>   | 16b SOCIAL SECURITY NO.<br><b>577 22 8893</b>  | 17 INFORMANT<br><b>Sam Chipouras (Husband)</b>   | ADDRESS<br><b>Same as 13E</b>  |   |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <i>cardiovascular arrest</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10/29</b>  |  |  |  |   |   |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>heart failure</i> <b>10/14</b>  |  |  |  |   |   |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>severe coronary/obstruction</i> <b>10/14</b>  |  |  |  |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION ON LINE 18<br><i>Rheumatoid arthritis, UTI, bleeding when resection of sigmoid colon</i>   |  |  |  |   |   |
| 19a DATE OF OPERATION<br><b>9/19/85</b>  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Rectal bleed</b>   | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |   |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)<br><b>None</b>  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>None</b>                                    |  |   |   |
| 21d INJURY OCCURRED<br><b>None</b>   | 21e PLACE OF INJURY<br>(ENT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>None</b>  | 21f LOCATION<br>STREET<br><b>None</b>  | CITY OR TOWN<br><b>None</b>  |   |   |
| 22a I certify that (i) this hospital attended the deceased from <b>10/17</b> to <b>10/29</b> , 19 <b>85</b> , that (ii) we last saw the deceased alive on <b>10/26</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (i) (we) did/did not view the body after death. |  |  |  |   |   |
| 22b SIGNATURE<br><i>Arthur S. Szwarc</i>   | DEGREE<br><b>MD</b>  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c DATE SIGNED<br><b>10/29/85</b>   |   |   |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Arthur Szwarc</b>   | 22e ADDRESS<br><b>1811 Peach Dr. 20832</b>   | 23a BURIAL, CREMATION, REMOVAL<br>(SOCIETY)<br><b>Burial</b>   | 23b DATE<br><b>11/2/85</b>   | 23c NAME OF CEMETERY OR CREMATORIAL<br><b>Gate of Heaven</b>          | 23d LOCATION<br>CITY OR TOWN<br><b>S.S. Mont. Md.</b> |
| 24 FUNERAL DIRECTOR<br><b>Hines/Rinaldi</b>  | 25a ADDRESS<br><b>11800 New Hamp. Ave. S.S. Md.</b>  | 25b DATE REC'D. BY REGISTRAR<br><b>OCT 31 1985</b>   | 25c REGISTRAR'S SIGNATURE<br><i>Hines/Rinaldi</i>  |   |   |

303047



85 28 179

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

298117

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician it should be detached for use at the burial or cremation. Then please remove from paper program page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or other disposition.

IMPORTANT: If item 21 is marked or checked, all other injury, or other traumatic event, the medical examiner must be notified in writing.

|  |  |   |  |   |  |  |  |                                   |     |                            |          |  |  |                                |  |
|--|--|---|--|---|--|--|--|-----------------------------------|-----|----------------------------|----------|--|--|--------------------------------|--|
| 1 - STATE REGISTRAR  |  |   |  | REG. NO. _____  |  |  |  |                                   |     |                            |          |  |  |                                |  |
| I. DECEASED NAME<br>(TYPE OR PRINT)  |  |   |  | LAST  |  | 2d. DATE OF DEATH  |  | MONTH                             | DAY | YEAR                       | 2b. HOUR |  |  |                                |  |
| JAMES CHURCHMAN  |  |   |  | CHURCHMAN   |  | 10-17-85   |  | 10:43 AM                          |     |                            |          |  |  |                                |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR                   |     | IF UNDER 24 HRS            |          |  |  |                                |  |
| Male   |  | USA   |  | 12-24-05  |  | 79 YRS   |  | MONTHS                            |     | DAYS                       |          |  |  |                                |  |
| 7e. BIRTHPLACE   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  | Montgomery County MD.             |     |                            |          |  |  |                                |  |
| Virginia   |  | USA   |  | Holy Cross Hospital   |  | 10a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 11b. KIND OF BUSINESS OR INDUSTRY |     |                            |          |  |  |                                |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. CITY OR TOWN   |  | 13a. STATE   |  | 13b. COUNTY                       |     | 13c. CITY OR TOWN          |          | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE |  |
| Silver Spring  |  | Holy Cross Hospital   |  | Silver Spring   |  | MD   |  | Montgomery                        |     | Silver Spring              |          | YES <input type="checkbox"/> NO <input type="checkbox"/>                             |  | 306 Salem Street 20910         |  |
| 14. FATHER'S NAME  |  | FIRST MIDDLE LAST   |  | 15. MOTHER'S MAIDEN NAME  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.          |     | 17. INFORMANT              |          | ADDRESS  |  |                                |  |
| (If Yes give war or dates)   |  | (If Yes give war or dates)  |  | (If Yes give war or dates)  |  | (If Yes give war or dates)   |  | (If Yes give war or dates)        |     | (If Yes give war or dates) |          | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                      |  |                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c).<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)   |  | aspiration pneumonia  |  | 4 days  |  | (b) small bowel obstruction  |  | 4 days                            |     |                            |          |  |  |                                |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost  |  | DUE TO, OR AS A CONSEQUENCE OF  |  | (c)   |  |  |  |                                   |     |                            |          |  |  |                                |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a  |  |   |  |   |  |  |  |                                   |     |                            |          |  |  |                                |  |
| alcoholism   |  |   |  |   |  |  |  |                                   |     |                            |          |  |  |                                |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  |                                   |     |                            |          |  |  |                                |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |                                   |     |                            |          |  |  |                                |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)                                     |  | 21f. LOCATION<br>STREET   |  | CITY OR TOWN   |  | COUNTY                            |     | STATE                      |          |  |  |                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Oct 13, 1985, to Oct 17, 1985, that (I) (we) last saw the deceased alive on Oct 17, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (II) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |                                   |     |                            |          |  |  |                                |  |
| 27e. DATE SIGNED<br>10/17/85   |  | 27f. SIGNATURE<br>Stephen Helman  |  | 27g. DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |                                   |     |                            |          |  |  |                                |  |
| 27h. PHYSICIAN'S NAME<br>Stephen Helman  |  | 27i. ADDRESS<br>6246 Montrose Rd, Rockville, MD   |  |   |  |  |  |                                   |     |                            |          |  |  |                                |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Removal  |  | 23b. DATE<br>10-19-85   |  | 23c. NAME OF CEMETERY OR CREMATORIAL<br>Anatomy Board Baltimore, Maryland   |  | 23d. LOCATION<br>CITY OR TOWN  |  | COUNTY                            |     | STATE                      |          |  |  |                                |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>State Anatomy Board Baltimore, Maryland  |  | 25a. DATE REC'D. BY REGISTRAR<br>Oct 24 1985  |  | 25b. REGISTRAR'S SIGNATURE<br>Julie Davidson-Pender   |  |  |  |                                   |     |                            |          |  |  |                                |  |
| DHMH - 16 60M 7/84<br>(VRA 15, 4)  |  |   |  |   |  |  |  |                                   |     |                            |          |  |  |                                |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - STATE REGISTRAR

|   |  |   |       |  |   |   |  |                                      |  |   |  |   |  |
|---|--|---|-------|--|---|---|--|--------------------------------------|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   | FIRST | MIDDLE   | LAST  | 2a DATE OF DEATH  | MONTH  | DAY                                  | YEAR   | 2b HOUR                                   |  |   |  |
| JONATHAN ROY ROBERT COE   |  |   |       |  |   | OCTOBER 26, 1985  |  |                                      | A 7:30   |   |  |   |  |
| 3. SEX  |  | 4. RACE   |       | 5. DATE OF BIRTH<br>MONTH DAY YEAR   |   |   | 6. AGE (IN YEARS LAST BIRTHDAY)  |                                      |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |  |   |  |
| MALE  |  | WHITE   |       | SEPTEMBER 12, 1958   |   |   | 27   |                                      |  |   |  |   |  |
| 7a BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |       | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |   | 9 BALTIMORE CITY OR COUNTY OF DEATH  |                                      |  | MD.                                       |  |   |  |
| OREGON  |  | USA   |       |  |   |   | MONTGOMERY COUNTY  |                                      |  |   |  |   |  |
| 10 CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |       |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |   |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY |  |   |  |   |  |
| BETHESDA  |  | NIH, THE CLINICAL CENTER  |       |  | STUDENT   |   |  | LAY MINISTRY                         |  |   |  |   |  |
| 13a STATE   |  | 13b. COUNT  |       | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                                      | 13e. STREET ADDRESS / ZIP CODE   |   |  |   |  |
| VIRGINIA  |  |   |       | ARLINGTON  |   |   |  |                                      | 2909 N. 24th STREET 22207  |   |  |   |  |
| 14 FATHER'S NAME<br>FIRST   |  | MIDDLE  | LAST  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |   |   |  |                                      |  |   |  |   |  |
| DOUGLAS   |  | EVANS   | COE   | JANICE MUYSKENS  |   |   |  |                                      |  |   |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES NO OR UNKNOWN)  |  | (IF YES, GIVE WAR OR DATES)   |       | 16b SOCIAL SECURITY NO   |   | 17 INFORMANT  |  |                                      | ADDRESS  |   |  |   |  |
| NO  |  | N/A   |       | 579-62-1627  |   | Mrs. Lisa A. Coe, wife, same  |  |                                      |  |   |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a)<br><br>DUE TO, OR AS A CONSEQUENCE OF<br>Pneumonia<br>(b)<br><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Diffuse histiocytic lymphoma   |  |   |       |  |   |   |  |                                      |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |       |  |   |   |  |                                      |  |   |  |   |  |
| 19a DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |       |  |   |   | 20a AUTOPSY?   |                                      | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |   |   |  |                                      |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |       | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |  |                                      |  |   |  |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from March 11, 1985, to October 26, 1985, that (X) (we) last<br>saw the deceased alive on October 26, 1985, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (X) (we) (did) (not) view the body after death. |  |   |       |  |   |   |  |                                      |  |   |  | 22c. DATE SIGNED<br>10/26/85                    |  |
| 22b. SIGNATURE<br>Mark J. Cooper MD   |  | DEGREE  |       |  |   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                      |  |   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MARK J. COOPER MD  |  | 22e. ADDRESS<br>9000 ROCKVILLE PIKE, NATIONAL<br>INSTITUTES OF HEALTH, BETHESDA, MD 20892                 |       |  |   |   |  |                                      |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>BURIAL   |  | 23b. DATE<br>10-28-85   |       | 23c. NAME OF CEMETERY OR CREMATORIUM<br>COLUMBIA GARDENS   |   |   | 23d. LOCATION<br>CITY OR TOWN<br>ARLINGTON, VIRGINIA   |                                      |  |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>IVES-PEARSON FUNERAL HOMES<br>ARLINGTON, Va. 22201  |  |   |       |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 1 1985  |                                      | 25b. REGISTRAR'S SIGNATURE<br>June Sander Rodell   |   |  |   |  |
| DHMH - 16 60M 7/84<br>(VRA 15-4)  |  |   |       |  |   |   |  |                                      |  |   |  |   |  |

CLASSIC



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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

85 28 981

|  |   |   |   |  |  |   |                                      |                   |                            |
|--|---|---|---|--|--|---|--------------------------------------|-------------------|----------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |   |   | FIRST<br><b>FLORENCE</b>  | MIDDLE<br><b>V.</b>  | LAST<br><b>COLE</b>  | 2a. DATE OF DEATH<br>MONTH<br><b>10</b> | DAY<br><b>18</b>                     | YEAR<br><b>85</b> | 2b. HOUR<br><b>4:29 PM</b> |
| 3. SEX<br><b>FEMALE</b>  | 4. RACE<br><b>WHITE</b>   | 5. DATE OF BIRTH<br>MONTH<br><b>10</b>  | DAY<br><b>01</b>  | YEAR<br><b>97</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>88</b><br>YRS  | IF UNDER 1 YEAR<br>MONTHS<br><b>0</b>   | IF UNDER 24 HRS<br>HOURS<br><b>0</b> | MIN.<br><b>0</b>  |                            |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)<br><b>MARYLAND</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b>                                       |  |  |   |                                      |                   |                            |
| 10. CITY OR TOWN OF DEATH<br><b>ROCKVILLE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SHADY GROVE ADVENTIST</b> |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOMEMAKER</b> | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br><b>Own Home</b>  |   |                                      |                   |                            |
| 13a. STATE<br><b>MD</b>  | 13b. COUNTY<br><b>MONTGOMERY</b>  | 13c. CITY OR TOWN<br><b>DERWOOD</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>17808 CADDY DRIVE / 20855</b>                   |  |   |                                      |                   |                            |
| 14. FATHER'S NAME<br>FIRST<br><b>Byron</b>   | MIDDLE<br><b>Trevey</b>   | LAST<br><b>Ada</b>  | 15. MOTHER'S MAIDEN NAME<br>FIRST<br><b>Pumphrey</b>  |  |  |   |                                      |                   |                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>N/A</b>   | 17. INFORMANT<br>(Daughter) ADDRESS<br><b>Brabara C. Lassiter Derwood, Maryland</b>   |   |  |  |   |                                      |                   |                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b>   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>25 minutes</b>                            |  |  |   |                                      |                   |                            |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause lost.<br>(b) <b>COLON DISTENSION - PERFORATION</b>   |   |   | <b>3 days</b>   |  |  |   |                                      |                   |                            |
| (c) <b>STERCORAL IMPACTION - OBSTRUCTION</b>   |   |   | <b>7 days</b>   |  |  |   |                                      |                   |                            |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).<br><b>OSTEOPOROSIS, VERTEBRAL COMPRESSION FRACTURES</b>  |   |   |   |  |  |   |                                      |                   |                            |
| 19a. DATE OF OPERATION<br><b>NONE</b>  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |                                      |                   |                            |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |  |  |   |                                      |                   |                            |
| 21d. INJURY OCCURRED<br>WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET<br>CITY OR TOWN<br>COUNTY<br>STATE  |   |  |  |   |                                      |                   |                            |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>JANUARY 19 84</b> to <b>10/18 19 85</b> , that (I) <input type="checkbox"/> lost<br>saw the deceased alive on <b>10/18 19 85</b> , and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated<br>above, (I) <input type="checkbox"/> (did) <input type="checkbox"/> view the body after death. |   |   |   |  |  |   |                                      |                   |                            |
| 22b. SIGNATURE<br><b>Alan N. Schulman, M.D.</b>  | DEGREE  | ATTENDING<br>PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF<br>PHYSICIAN <input type="checkbox"/>                    | 22c. DATE SIGNED<br><b>10/19/85</b>   |  |  |   |                                      |                   |                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ALAN N. SCHULMAN, M.D.</b>   | 22e. ADDRESS<br><b>9715 MEDICAL CENTER DR. ROCKVILLE MD. 20850</b>  |   |   |  |  |   |                                      |                   |                            |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  | 23b. DATE<br><b>October 21, 1985</b>  | NAME OF CEMETERY OR CREMATORIUM<br><b>Parklawn Memorial</b>   | 23d. LOCATION<br>CITY OR TOWN<br><b>Rockville</b>   | 23e. COUNTY<br><b>Maryland</b>   |  |   |                                      |                   |                            |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>P.A. 300 W. Montgomery Ave, Rockville, MD</b>   | 24b. ADDRESS<br><b>Robert A. Pumphrey Funeral Home</b>  | 24c. DATE REC'D. BY REGISTRAR<br><b>OCT 23 1985</b>   | 24d. REGISTRAR'S SIGNATURE<br><b>Johanna Anderson</b>   |  |  |   |                                      |                   |                            |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

relinquished by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

REPORT: If item 21 is marked as Item 18 above any injury or other traumatic event, the medical examiner should be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be submitted to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the funeral director's panel. Then please send carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, this medical examiner must be informed.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |                                      |   |  |  |                                |   | 85 28982                                       |                             |   |                 |         |
|--|--|---|--|--------------------------------------|---|--|--|--------------------------------|---|--|-----------------------------|---|-----------------|---------|
| 1 - STATE REGISTRAR  |  | REG. NO.  |  |                                      |   |  |  |                                |   |  |                             |   |                 |         |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST   |  |                                      | MIDDLE  |  | LAST   |                                |   | 2a DATE OF DEATH                               | MONTH                       | DAY   | YEAR            | 2b HOUR |
| William C  |  |   |  |                                      |   |  | Coke, JR.  |                                |   | 10-4-85  |                             |   |                 | 6:18 M  |
| 3. SEX   |  | 4. RACE   |  |                                      | 5. DATE OF BIRTH  |  |  |                                |   | 6. AGE (IN YEARS LAST BIRTHDAY)                | IF UNDER 1 YEAR             |   | IF UNDER 24 MRS |         |
| Male   |  | White   |  |                                      | Month<br>4-29-10 Year   |  |  |                                |   | 75   | MONTHS                      | DAYS  | HOURS           | MIN.    |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  |                                      | 8   |  | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                |   | 9. BALTIMORE CITY OR COUNTY OF DEATH           |                             |   |                 |         |
| D.C.   |  | U.S.A.  |  |                                      | 8   |  |  |                                |   | MONTGOMERY                                     |                             |   |                 |         |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                                      | 12a. USUAL OCCUPATION<br>(TYPE OF WORKING LIFE)                                 |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY   |                                |   |  |                             |   |                 |         |
| Silver Spring  |  | Holy Cross Hospital   |  |                                      | TRAFFIC MGM.<br>SPECIALIST  |  | DEPT OF ARMY   |                                |   |  |                             |   |                 |         |
| 13a. STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN                    |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> XXX |  | 13e. STREET ADDRESS / ZIP CODE |   |  |                             |   |                 |         |
| MARYLAND   |  | MONTGOMERY  |  | SILVER SPRING                        |   | YES <input type="checkbox"/> XXX                             |  | 107155 GATES AVENUE 2090       |   |  |                             |   |                 |         |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME  |  |                                      |   |  |  |                                |   |  |                             |   |                 |         |
| FIRST<br>WILLIAM   |  | MIDDLE<br>C.  |  |                                      | LAST<br>COLE, SR.   |  | FIRST<br>ELIZABETH   |                                |   | MIDDLE   |                             | LAST<br>WARDEN                                  |                 |         |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.  |  |                                      | 17. INFORMANT   |  | 18. CAUSE OF DEATH (Enter only one cause per line for 1a, b, and c)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (1a)                              |                                |   | ADDRESS  |                             | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |                 |         |
| NO   |  | 578-32-6714   |  |                                      | DAUGHTER<br>DIANE ADAMS   |  | Spontaneous hemorrhage<br>Abdominal carcinomatous  |                                |   | 10503 HUNTER PLACE<br>SILVER SPRING, MD. 20902 |                             | By<br>In.                                       |                 |         |
| 18c. DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which<br>gave rise to immediate<br>cause (1a), stating the<br>underlying cause last.  |  | (1b)  |  |                                      | DUE TO, OR AS A CONSEQUENCE OF<br>Colon cancer                                  |  |  |                                |   |  |                             |   |                 |         |
| (1c)   |  |   |  |                                      |   |  |  |                                |   |  |                             |   |                 |         |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a  |  |   |  |                                      |   |  |  |                                |   |  |                             |   |                 |         |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |                                      | 20a. AUTO/PST   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?  |                                |   |  |                             |   |                 |         |
|  |  |   |  |                                      | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                |   |  |                             |   |                 |         |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |                                      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY FROM ITEM 1b PART 1 OR PART 2) |  |  |                                |   |  |                             |   |                 |         |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  |                                      | 21f. LOCATION<br>STREET   |  | CITY OR TOWN   |                                | COUNTY  |  | STATE                       |   |                 |         |
| 22a. I certify that (I) (this hospital) attended the deceased from<br>the deceased alive on 10/9/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) did (not) view the body after death. |  |   |  |                                      | 22b. SIGNATURE<br>Martin O'Malley Jr.   |  | DEGREE   |                                | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>10/4/85 |   |                 |         |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS  |  |                                      |   |  |  |                                |   |  |                             |   |                 |         |
| Martin J. Ward 9515 Greenway Ln. Greenbelt MD 20770  |  |   |  |                                      |   |  |  |                                |   |  |                             |   |                 |         |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORIUM |   |  | 23d. LOCATION<br>CITY OR TOWN  |                                | COUNTY  |  | STATE                       |   |                 |         |
| BURIAL   |  | 10/9/85   |  | PARKLAWN CEMETERY                    |   |  | ROCKVILLE  |                                | MONT  |  | MD.                         |   |                 |         |
| 24. FUNERAL DIRECTOR<br>NAME   |  | FRANCIS J. COLLINS, JR.   |  |                                      | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE   |                                |   |  |                             |   |                 |         |
|  |  |   |  |                                      | OCT 9 1985  |  |  |                                |   |  |                             |   |                 |         |
|  |  | 500 UNIV. BLVD. W., SILVER SPRING, MD. 20901  |  |                                      |   |  |  |                                |   |  |                             |   |                 |         |

of 1928

One Million

Five Hundred

Twenty Five

Millions

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ation and Development Corporation

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and carbon copies made, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

Important: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certification section must be completed.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |       |   |      |   |  |        |                                   | 8 5 2 8 7 8 3  |                                  |   |  |
|---|--|--|-------|---|------|---|--|--------|-----------------------------------|--|----------------------------------|---|--|
|   |  |  |       |   |      |   |  |        |                                   | REG. NO.   |                                  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  | FIRST | MIDDLE  | LAST | 2a DATE OF DEATH                                  |  | MONTH  | DAY                               | YEAR   | 2b HOUR                          |   |  |
| FRANCIS JOSEPH COLLINS  |  |  |       |   |      | OCTOBER 1, 1985                                   |  |        |                                   |  | 12:39 PM                         |   |  |
| 3. SEX  |  | 4. RACE  |       | 5. DATE OF BIRTH<br>MONTH DAY YEAR  |      |   | 6. AGE (IN YEARS LAST BIRTHDAY)  |        | 7. IF UNDER 1 YEAR<br>MONTHS DAYS |  | 8. IF UNDER 24 HRS<br>HOURS MIN. |   |  |
| MALE  |  | CAUCASIAN  |       | MARCH 1, 1901   |      |   | 84 YRS   |        |                                   |  |                                  |   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |       | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |      |   | 9. BALTIMORE CITY OR COUNTY OF DEATH   |        | MD.                               |  |                                  |   |  |
| WASHINGTON, D.C.  |  | U.S.A.   |       |   |      |   | MONTGOMERY   |        |                                   |  |                                  |   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                          |       |   |      |   |  |        |                                   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     |                                  | 12b. KIND OF BUSINESS<br>INDUSTRY   |  |
| SILVER SPRING   |  | HOLY CROSS HOSPITAL  |       |   |      |   |  |        |                                   | FUNERAL DIRECTOR, FUNERAL HOME   |                                  |   |  |
| 13a. STATE  |  | 13b. COUNTY  |       | 13c. CITY OR TOWN   |      |   | 13d. INSIDE CITY LIMITS?<br><input type="checkbox"/> <input checked="" type="checkbox"/> |        | 13e. STREET ADDRESS / ZIP CODE    |  | 13f. ZIP CODE                    |   |  |
| MARYLAND  |  | MONTGOMERY   |       | SILVER SPRING   |      |   |  |        | 9617 SUTHERLAND ROAD              |  | 20901                            |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST  |       |   |      |   |  |        |                                   |  |                                  |   |  |
| JOHN PATRICK COLLINS  |  | MARY ALOYSIUS COLLINS  |       |   |      |   |  |        |                                   |  |                                  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |       | 17. INFORMANT   |      | ADDRESS   |  |        |                                   |  |                                  |   |  |
| NO  |  | 578-14-6358  |       | CATHARINE COLLINS   |      | SAME AS 13 WIFE                                   |  |        |                                   |  |                                  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a)   |  |  |       |   |      |   |  |        |                                   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                      |                                  |   |  |
| Acute coronary insufficiency  |  |  |       |   |      |   |  |        |                                   | sudden   |                                  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) Coronary arteriosclerotic disease   |  |  |       |   |      |   |  |        |                                   | 5 yrs  |                                  |   |  |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause lost<br>(c) Gen. arteriosclerosis   |  |  |       |   |      |   |  |        |                                   |  |                                  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a<br>Severe arthritis of spine  |  |  |       |   |      |   |  |        |                                   |  |                                  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |       |   |      |   |  |        |                                   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |       | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)  |      |   |  |        |                                   |  |                                  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |       | 21f. LOCATION<br>STREET   |      | CITY OR TOWN                                      |  | COUNTY |                                   | STATE  |                                  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan. 19, 72 to Oct 1, 1985, that (I) (we) last<br>saw the deceased alive on Oct 1, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |       |   |      |   |  |        |                                   |  |                                  |   |  |
| 22b. SIGNATURE<br>Thomas F. McMahon MD  |  | DEGREE   |       |   |      |   |  |        |                                   | 22c. DATE SIGNED<br>10-1-85  |                                  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |       |   |      |   |  |        |                                   |  |                                  |   |  |
| THOMAS F. MCMAHON   |  | 22e. ADDRESS<br>2737 DEVONSHIRE PLACE, N.W., WASHINGTON, D.C.  |       |   |      |   |  |        |                                   |  |                                  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE<br>BURIAL 10/5/85  |       | 23c. NAME OF CEMETERY OR CREMATORIUM<br>MT. OLIVET CEMETERY   |      | 23d. LOCATION<br>CITY OR TOWN<br>WASHINGTON, D.C. |  | COUNTY |                                   | STATE  |                                  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>FRANCIS J. COLLINS, JR.<br>ADDRESS<br>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901   |  | 25. DATE REC'D. BY REGISTRAR<br>REGISTRAR'S SIGNATURE<br>OCT 7 1985 Julia Davidson-Pendell   |       |   |      |   |  |        |                                   |  |                                  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please sign and return it to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |                     |   |  |                                   |                                      |                                 |                 | 85 28 84   |                 |                               |            |          |
|--|--|--|--|---|---------------------|---|--|-----------------------------------|--------------------------------------|---------------------------------|-----------------|--|-----------------|-------------------------------|------------|----------|
|  |  |  |  |   |                     |   |  |                                   |                                      |                                 |                 | REG. NO.   |                 |                               |            |          |
| 1. FOR<br>STATE<br>REGISTRAR   | 1. DECEASED NAME<br>(TYPE OR PRINT)                                    |  |  |   |                     |   |  |                                   |                                      |                                 |                 | 2a. DATE OF DEATH  | MONTH           | DAY                           | YEAR       | 2b. HOUR |
|  | Davidson MIDDLE E LAST Cook  |  |  |   |                     |   |  |                                   |                                      |                                 |                 | 10   | 6               | 85                            | 10 35 P.M. |          |
| 3. SEX   | M ale  |  | 4. RACE  | White   |                     | 5. DATE OF BIRTH  | MONTH  | DAY                               | YEAR                                 | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR |  | IF UNDER 24 HRS |                               |            |          |
|  |  |  |  |   |                     |   | 4  | 4                                 | 11                                   | 74                              | MONTHS          | DAYS   | HOURS           | MIN.                          |            |          |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)  | Ohio   |  | 7b. CITIZEN OF WHAT COUNTRY?   | USA   |                     | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | WIDOWED <input type="checkbox"/>   | DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH |                                 |                 |  |                 |                               |            |          |
| 10. CITY OR TOWN OF DEATH  | Bethesda   |  |  |   |                     |   |  |                                   |                                      |                                 |                 | Montgomery   |                 |                               |            |          |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  | Suburbans Hospital   |  |  |   |                     |   |  |                                   |                                      |                                 |                 | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |                 |                               |            |          |
| 13a. STATE   | Maryland   | 13b. COUNTY  | Montgomery   | 13c. CITY OR TOWN                                 | Rockville           | 13d. INSIDE CITY LIMITS?  | YES <input type="checkbox"/>   | NO <input type="checkbox"/>       | 13e. STREET ADDRESS / ZIP CODE       |                                 |                 |  |                 |                               |            |          |
| 14. FATHER'S NAME  | FIRST<br>Charles   | MIDDLE<br>F.   | LAST<br>Cook   | 15. MOTHER'S MAIDEN NAME                          | FIRST<br>Maude      | MIDDLE<br>Marion  | LAST<br>Davidson   |                                   |                                      |                                 |                 |  |                 |                               |            |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES  | WWII & Korea   |  | 16b. SOCIAL SECURITY NO.   | 572-22-1211                                       |                     | 17. INFORMANT   | ADDRESS  |                                   |                                      |                                 |                 |  |                 |                               |            |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |   |                     |   |  |                                   |                                      |                                 |                 | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>Immediate<br>Unknown<br>Unknown<br>1 year.  |                 |                               |            |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |   |                     |   |  |                                   |                                      |                                 |                 |  |                 |                               |            |          |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  |   | 20a. AUTOPSY?       |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   |                                      |                                 |                 |  |                 |                               |            |          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |                     |   |  |                                   |                                      |                                 |                 |  |                 |                               |            |          |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET _____<br>CITY _____ COUNTY _____ STATE _____           |   |                     |   |  |                                   |                                      |                                 |                 |  |                 |                               |            |          |
| 22a. I certify that (1) (the hospital) attended the deceased from 10/7/85 to 10/6/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.   |  |  |  |   |                     |   |  |                                   |                                      |                                 |                 | 22b. SIGNATURE<br><i>Allen J. O'Neill MD</i>   | DEGREE<br>MD    | 22c. DATE SIGNED<br>10/7/1985 |            |          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  | 22e. ADDRESS<br>8601 1/2 Georgetown Rd, Bethesda Md                    |  |  |   |                     |   |  |                                   |                                      |                                 |                 | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                 |                               |            |          |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPEC#)   | 23b. DATE<br>Burial 10/11/1985   | 23c. NAME OF CEMETERY OR CREMATORIY<br>Arlington National Cemetery | 23d. LOCATION<br>CITY OR TOWN<br>Arlington, Va.                                | 23e. COUNTY<br>County                             | 23f. STATE<br>State |   |  |                                   |                                      |                                 |                 |  |                 |                               |            |          |
| 24. FUNERAL DIRECTOR<br>Joseph Gawler's Sons Inc.<br>5130 1/2 Wisc. Ave., N.W. Wash., D.C.   |  |  | 25a. DATE REC'D. BY REGISTRAR<br>Oct 10 1985                                   | 25b. REGISTRAR'S SIGNATURE<br><i>Julia Martin</i> |                     |   |  |                                   |                                      |                                 |                 |  |                 |                               |            |          |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER (ITEM 10) WITH FORM PM. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 4 AND 25 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |              |  |   |  |  |  |  |  |  | REG. NO. 8528985   |  |  |
|--|--------------|--|---|--|--|--|--|--|--|--|--|--|
| 1- STATE REGISTRAR   |              |  | 1 DECEASED NAME FIRST MIDDLE LAST           |  |  |  |  |  |  | 2a. DATE KNOWN OF ESTI-<br>DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 10/06 1985 7:10 P.M. |  |  |
| Louise G. Cooley   |              |  |   |  |  |  |  |  |  | 2b. HOUR 2d HOUR 7:10 P.M.   |  |  |
| 3 SEX Female   | 4 RACE White | 5 DATE OF BIRTH MONTH DAY YEAR Nov. 26 1898  | 6 AGE (IN YEARS)<br>(LAST BIRTHDAY) 86 YRS. | IF UNDER 1 YR.<br>MONTHS DAYS  | IF UNDER 24 HRS.<br>HOURS MIN.   | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR 10/06 1985 7:10 P.M.                              |  |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Colorado   |              | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.  |   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County           |  |  |  |  |
| 10 CITY OR TOWN OF DEATH Bethesda  |              | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK)<br>FOR MOST OF WORKING LIFE) Fabric Restorer  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY Museums                        |  |  |  |  |
| 13a. STATE MD  |              | 13b. COUNTY MONTGOMERY   |   | 13c. CITY OR TOWN BETHESDA   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS 6506 WILMETT Rd. 20817                       |  |  |  |  |
| 14. FATHER'S NAME Charles  |              | FIRST MIDDLE LAST  |   | Richardson   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  | Goodwin  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) No   |              | 16b. SOCIAL SECURITY NO. 577-84-3149A  |   | 17. INFORMANT  |  | ADDRESS  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE |  |  |  |
| Theodore R Cooley. Same as item 13.  |              |  |   |  |  |  |  |  |  | INDEF  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) AFTERISCHEMIA/CARDIOVASCULAR DISEASE<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |              |  |   |  |  |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.<br>FRACTURED HIP  |              |  |   |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION SEPT 1985   |              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? FRACTURED HIP  |   | 20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                      |  |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |              | 21b. TIME OF INJURY HOUR AM MONTH DAY YEAR 6 P.M. 10 6 1985  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>COLLAPSED AT DUNN'S |  | 21d. LOCATION STREET   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) HOME |  | 21f. CITY OR TOWN MONT   |  |  |
| 21f. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/>  |              | 21g. COUNTY BETHESDA   |   | 21h. STATE MD  |  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>ACTUAL SIGNATURE Francis C. Mayle M.D.                                  |              |  |   |  |  |  |  |  |  | TITLE (SPECIFY) MEDICAL EXAMINER   |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) Francis C. Mayle ADDRESS 820 Wisconsin Ave. Bethesda MD 20814  |              |  |   |  |  |  |  |  |  | DATE SIGNED 10/8/85  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) Cremation   |              | 23b. DATE Oct. 9 1985  |   | 23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Crematory  |  | 23d. LOCATION CITY OR TOWN Suitland  |  | 23e. COUNTY Maryland   |  | 23f. STATE   |  |  |
| 24 FUNERAL DIRECTOR Joseph Gawler's Sons Inc.<br>NAME 5130 Wisc. Ave., N.W.<br>ADDRESS ash., D.C.  |              | 25a. DATE REC'D. BY REGISTRAR OCT 14 1985  |   | 25b. REGISTRAR'S SIGNATURE Julie K. [Signature]  |  |  |  |  |  |  |  |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8528980

1 - STATE  
REGISTRAR

REG. NO.

|   |  |   |       |   |      |   |       |  |      |                                 |  |
|---|--|---|-------|---|------|---|-------|--|------|---------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   | FIRST | MIDDLE  | LAST | 2a. DATE OF DEATH   | MONTH | DAY  | YEAR | 2b. HOUR                        |  |
| THEODORE R. COOLEY  |  |   |       |   |      | OCTOBER 29 1985   |       |  |      | 10:30 a.m.                      |  |
| 3. SEX  |  | 4. RACE   |       | 5. DATE OF BIRTH  |      | 6. AGE (IN YEARS LAST BIRTHDAY)   |       | IF UNDER 1 YEAR  |      | IF UNDER 24 HRS                 |  |
| MALE  |  | CAUCASIAN   |       | MONTH DAY YEAR<br>OCTOBER 5 1904  |      | 81 YRS  |       | MONTH DAYS   |      | HOURS MIN.                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>IOWA   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>UNITED STATES   |       | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY  |       |  |      |                                 |  |
| 10. CITY OR TOWN OF DEATH<br>BETHESDA   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>NAVAL HOSPITAL |       | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>RETIRED   |      | 12b. KIND OF BUSINESS OR INDUSTRY<br>U.S. NAVY  |       |  |      |                                 |  |
| 13a. STATE<br>MARYLAND  |  | 13b. COUNTY<br>MONTGOMERY   |       | 13c. CITY OR TOWN<br>BETHESDA   |      | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |       | 13e. STREET ADDRESS / ZIP CODE<br>6506 WILLMETT ROAD 20817   |      |                                 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>BOARDMAN COOLEY   |  |   |       | 15. MOTHER'S MAIDEN NAME<br>ADA MARSH   |      |   |       |  |      |                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES OR UNKNOWN)<br>YES   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>1920-1958  |       | 17. INFORMANT<br>JOHN A. COOLEY, 6506 WILLMETT ROAD, BETHESDA, MD   |      |   |       |  |      |                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PROSTATIC CARCINOMA</b><br>APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |   |       |   |      |   |       |  |      |                                 |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause last<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |   |       |   |      |   |       |  |      |                                 |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |       |   |      |   |       |  |      |                                 |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |       |   |      | 20a. AUTOPSY?   |       | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |      |                                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |      |   |       |  |      |                                 |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |       | 21f. LOCATION<br>STREET   |      | CITY OR TOWN  |       | COUNTY   |      | STATE                           |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>OCTOBER 12, 1985</b> to <b>OCTOBER 29, 1985</b> that (I) (we) last<br>saw the deceased alive on <b>OCTOBER 29, 1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |       |   |      |   |       |  |      |                                 |  |
| 22b. SIGNATURE<br><i>J. B. Hermiller</i>  |  | 22c. DEGREE   |       | ATTENDING PHYSICIAN <input type="checkbox"/>  |      | MEDICAL DIRECTOR <input type="checkbox"/>   |       | STAFF PHYSICIAN <input type="checkbox"/>   |      | DATE SIGNED<br><i>30 Oct 85</i> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>J. B. HERMILLER, LT, MC, USNR</b>   |  | 22e. ADDRESS<br>NAVAL HOSPITAL, NAVAL MEDICAL COMMAND,<br>NATIONAL CAPITAL REGION, BETHESDA, MD 20814                       |       |   |      |   |       |  |      |                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>10/4/85  |       | 23c. NAME OF CEMETERY OR CREMATORIAL<br>Arlington National Cem.   |      | 23d. LOCATION<br>CITY OR TOWN<br>Arlington  |       | COUNTY   |      | STATE<br>Virginia               |  |
| 24. FUNERAL DIRECTOR<br>Tyson Wheeler Funeral Home, Inc.<br>1331 Rockville Pike Rockville, Maryland 20852   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 08 1985  |       | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |      |   |       |  |      |                                 |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it must be given to the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 1 binds 2 securely but will be detached within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1 - STATE REGISTRAR

REG. NO.

|  |  |   |             |   |                          |   |              |   |              |   |       |
|--|--|---|-------------|---|--------------------------|---|--------------|---|--------------|---|-------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   | FIRST       | MIDDLE  | LAST                     | 2a. DATE OF DEATH   | MONTH        | DAY   | YEAR         | 2b. HOUR  |       |
| <b>DOROTHY</b>   |  |   | <b>Mary</b> |   | <b>COOMBS</b>            | <b>10-23-85</b>   |              |   |              | <b>5:24 P.M.</b>                                |       |
| 3 SEX  |  | 4 RACE  |             | 5. DATE OF BIRTH  |                          | 6. AGE (IN YEARS LAST BIRTHDAY)   |              | IF UNDER 1 YEAR   |              | IF UNDER 24 HRS                                 |       |
| <b>Female</b>  |  | <b>White</b>  |             | MONTH   | DAY                      | YEAR  | <b>72</b>    | MONTHS  | YEARS        | HOURS   | MIN.  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |             | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                          | 9. BALTIMORE CITY OR COUNTY OF DEATH  |              | MD.   |              |   |       |
| <b>MD</b>  |  | <b>USA</b>  |             |   |                          | <b>Montgomery</b>   |              |   |              |   |       |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |             |   |                          | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |              | 12b. KIND OF BUSINESS OR INDUSTRY   |              |   |       |
| <b>Takoma Park</b>   |  | <b>Washington Adventist Hospital</b>  |             |   |                          | <b>Homemaker</b>  |              | <b>Own home</b>   |              |   |       |
| 13a. STATE   |  | 13b. COUNTY   |             | 13c. CITY OR TOWN   |                          | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |              | 13e. STREET ADDRESS / ZIP CODE  |              | 20675   |       |
| <b>MD</b>  |  | <b>Charles</b>  |             | <b>Pomfret</b>  |                          | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                       |              | <b>Box 118H</b>   |              |   |       |
| 14. FATHER'S NAME  |  | FIRST   | MIDDLE      | LAST  | 15. MOTHER'S MAIDEN NAME |   | MIDDLE       | LAST  |              |   |       |
|  |  | <b>Henry</b>  | <b>Lee</b>  | <b>Welch</b>  |                          |   | <b>Susan</b> | <b>Lowellen</b>   | <b>Welch</b> |   |       |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |             |   |                          | 17. INFORMANT   |              | ADDRESS   |              |   |       |
| <b>No</b>  |  | <b>220-28-5229</b>  |             |   |                          | <b>son</b>  |              | <b>Box 146</b>  |              |   |       |
|  |  |   |             |   |                          | <b>Kenneth E. Coombs</b>  |              | <b>Pomfret, MD</b>  |              |   |       |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:   |  |   |             |   |                          |   |              |   |              | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |       |
| IMMEDIATE CAUSE (a)  |  | <b>Cardiorespiratory Arrest</b>   |             |   |                          |   |              |   |              |   |       |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.   |  | DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Cardiogenic Shock</b>  |             |   |                          |   |              |   |              |   |       |
|  |  | DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Extensive anterior wall myocardial infarction.</b>               |             |   |                          |   |              |   |              |   |       |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a  |  | <b>old anteroseptal wall myocardial Infarction.</b>   |             |   |                          |   |              |   |              |   |       |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |             |   |                          | 20a. AUTOPSY?<br><b>Created by</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |              | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |              |   |       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |             |   |                          | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                             |              |   |              |   |       |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |             |   |                          | 21f. LOCATION<br>STREET   |              | CITY OR TOWN  |              | COUNTY  | STATE |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10-23-</b> , 19 <b>85</b> , to <b>10-23-</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>10-23-</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |             |   |                          |   |              |   |              |   |       |
| 22b. SIGNATURE<br><i>Basir Mohamad</i>   |  |   |             |   |                          | DEGREE<br><b>M.D.</b>   |              | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>    |              | 22c. DATE SIGNED<br><b>10-23-85</b>             |       |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BASIR MOHAMAD F. KOLIA M.D.</b>  |  |   |             |   |                          | 22e. ADDRESS<br><b>9135 Piscataway Road,<br/>Clinton, MD 20735.</b>                                       |              |   |              |   |       |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>10/26/85</b>  |             | 23c. NAME OF CEMETERY OR CREMATORIAL<br><b>St. Joseph's Cemetery Pomfret,</b>   |                          | 23d. LOCATION<br>CITY OR TOWN<br><b>Charles</b>   |              | CITY OR TOWN<br><b>MD</b>   |              | COUNTY  | STATE |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Huntt Funeral Home, Waldorf, MD</b>  |  |   |             |   |                          | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 25 1985</b>   |              | 25b. REGISTRAR'S SIGNATURE<br><i>John Ryder</i>   |              |   |       |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and item 21 must be completed.)



312007

8 5 2 8 9 8 8

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|   |  |   |        |   |  |                   |   |  |      |   |      |                 |  |
|---|--|---|--------|---|--|-------------------|---|--|------|---|------|-----------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   | FIRST  | MIDDLE  | LAST   | 2a. DATE OF DEATH | MONTH   | DAY  | YEAR | 2b. HOUR  | P    |                 |  |
|   |  |   | Calvin | L.  | Copeland   | October 29, 1985  |   |  |      | 9:14  | M    |                 |  |
| 3. SEX  |  | 4. RACE   |        | 5. DATE OF BIRTH<br>MONTH DAY YEAR  |  |                   | 6. AGE (IN YEARS LAST BIRTHDAY)   |  |      | IF UNDER 1 YEAR                                 |      |                 |  |
| Male  |  | Black   |        | Dec. 1, 1935  |  |                   | 49  |  |      | MONTHS  | DAYS | IF UNDER 24 HRS |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                   | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |      | MD.   |      |                 |  |
| MD  |  | USA   |        |   |  |                   | Montgomery  |  |      |   |      |                 |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |        | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |                   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |      |   |      |                 |  |
| Olney   |  | Montgomery General Hospital   |        | Carpenter   |  |                   | City of Rock  |  |      | ville   |      |                 |  |
| 13a. STATE  |  | 13b. COUNTY   |        | 13c. CITY OR TOWN   |  |                   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |      | 13e. STREET ADDRESS / ZIP CODE                  |      |                 |  |
| MD  |  | Montg.  |        | Laytonsville  |  |                   | X   |  |      | Box 5021 /20879                                 |      |                 |  |
| 14. FATHER'S NAME<br>FIRST  |  | MIDDLE  |        | 15. MOTHER'S MAIDEN NAME<br>FIRST   |  |                   | MIDDLE  |  |      | LAST  |      |                 |  |
| George T. Copeland  |  |   |        | Annie R. Bright   |  |                   |   |  |      |   |      |                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |        | 17. INFORMANT   |  |                   | ADDRESS   |  |      | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |      |                 |  |
| No  |  | 214=32-8979   |        | Calvin Steward (son) same as #13  |  |                   |   |  |      | 2 years   |      |                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiomyopathy</u>   |  |   |        |   |  |                   |   |  |      |   |      |                 |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b)<br>(c)   |  |   |        |   |  |                   |   |  |      |   |      |                 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a<br><u>Hypertension</u>   |  |   |        |   |  |                   |   |  |      |   |      |                 |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |        |   | 20a. AUTOPSY?  |                   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |      |   |      |                 |  |
|   |  |   |        |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                   |   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |      |   |      |                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |        |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |                   |   |  |      |   |      |                 |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |        |   | 21f. LOCATION<br>STREET  |                   |   | CITY OR TOWN   |      |   |      |                 |  |
| 22a. I certify that (I) <u>the hospital</u> attended the deceased from <u>June 14, 1984</u> , to <u>October 29, 1985</u> , that (I) <u>was</u> last saw the deceased alive on <u>October 19, 1985</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>did not</u> view the body after death. |  |   |        |   |  |                   |   |  |      |   |      |                 |  |
| 22b. SIGNATURE<br><u>Barry Dees, M.D.</u>   |  | DEGREE  |        |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                   |   | 22c. DATE SIGNED<br><u>October 31, 1985</u>                    |      |   |      |                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Barry Dees</u>  |  | 22e. ADDRESS<br><u>3929 FERRARA DRIVE WHEATON, MARYLAND</u>   |        |   |  |                   |   |  |      |   |      |                 |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE   |        | 23c. NAME OF CEMETERY OR CREMATORIAL  |  |                   | 23d. LOCATION<br>CITY OR TOWN   |  |      | STATE   |      |                 |  |
| Burial  |  | 11-2-85   |        | Brooke Grove Cem.   |  |                   | Latonsville, Montg., MD   |  |      |   |      |                 |  |
| 24. FUNERAL DIRECTOR<br>NAME  |  | ADDRESS   |        |   | 25. DATE RECD. REGISTRAR REC'D.  |                   |   |  |      |   |      |                 |  |
| George R. Snowden   |  | Rockville, MD 20850   |        |   | NOV 04 1985  |                   |   |  |      |   |      |                 |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove the seal. Pages 1 and 2 should be filed within 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or other disposition.

IMPORTANT: If Item 21 is marked & Item 18 is any injury, or other traumatic event, the physician must sign and date this certificate.

STC90A



289067

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 2 8 9 8 9

1 - STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |  |                                      |  |  |   |          |       |
|--|--|---|--|---|--|--------------------------------------|--|--|---|----------|-------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   | FIRST  | MIDDLE  | LAST   | 2a. DATE OF DEATH                    | MONTH  | DAY  | YEAR  | 2b. HOUR |       |
|  |  |   | ANNA   | MARIE   | COUPLET  | OCT 10, 1985                         |  |  |   | 7:30 AM  |       |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)      |  |  |   |          |       |
| FEMALE   |  | CAUCASIAN   |  | MAY 2, 1902   |  | 83                                   |  |  |   |          |       |
| BIRTHPLACE<br>COUNTRY  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |  |   |          |       |
| FRANCE   |  | U.S.A.  |  |   |  | MONTGOMERY                           |  |  |   | MD.      |       |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY    |  |  |   |          |       |
| SILVER SPRING  |  | SYLVAN MANOR HEALTH CARE CENTER   |  | HOUSEWIFE   |  |                                      |  |  |   |          |       |
| 13a. STATE   |  |   | 13b. COUNTY  |   | 13c. CITY OR TOWN  |                                      | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE                                    |          |       |
| MARYLAND   |  |   | MONTGOMERY   |   | ROCKVILLE  |                                      | YES <input type="checkbox"/>   |  | 14643 BAUER DRIVE   |          | 20853 |
| 14. FATHER'S NAME  |  |   | FIRST  | MIDDLE  | LAST   | 15. MOTHER'S MAIDEN NAME             |  |  |   |          |       |
|  |  |   | GEANGUIMMUM  |   | ANSQUER  | MARIANNE                             |  |  |   |          |       |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |   | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT  |                                      | ADDRESS  |  | 18. APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH               |          |       |
| NO   |  |   | 016-07-5594  |   | DAUGHTER   |                                      | 10413 TINBROOK DRIVE   |  |   |          |       |
|  |  |   |  |   | LILLIAN L. McBRIDE   |                                      | SILVER SPRING, MD. 20901   |  |   |          |       |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardiovascular collapse</u>  |  |   |  |   |  |                                      |  |  |   |          |       |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>malignant mesothelioma Right</u>  |  |   |  |   |  |                                      |  |  |   |          |       |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause last   |  |   |  |   |  |                                      |  |  |   |          |       |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>side chest with malignant osteoid</u>   |  |   |  |   |  |                                      |  |  |   |          |       |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a<br><u>for metastasis</u>  |  |   |  |   |  |                                      |  |  |   |          |       |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  |                                      | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH? |          |       |
|  |  |   |  |   |  |                                      | YES <input type="checkbox"/> NO <input type="checkbox"/>                             |  | YES <input type="checkbox"/> NO <input type="checkbox"/>          |          |       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |                                      |  |  |   |          |       |
| 21d. INJURY OCCURRED<br>WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET  |                                      |  | CITY OR TOWN   | COUNTY  | STATE    |       |
| 22a. I certify that (i) (this hospital) attended the deceased from <u>1973</u> to <u>10/9/85</u> , that (ii) we last<br>saw the deceased alive on <u>10/9/85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (h) (we) (did) (did not) view the body after death. |  |   |  |   |  |                                      |  |  |   |          |       |
| 22b. SIGNATURE<br><u>Joseph M. Solinas</u>   |  |   | DEGREE<br><u>Mr</u>  |   | ATTENDING<br>PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> MEDICAL PHYSICIAN <input type="checkbox"/> |                                      |  | 22c. DATE SIGNED<br><u>10/10/85</u>                          |   |          |       |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>JOSEPH SOLINAS</u>   |  |   | 22e. ADDRESS<br><u>9801 GEORGIA AVE., SILVER SPRING, MD.</u>           |   |  |                                      |  |  |   |          |       |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  |   | 23b. DATE<br><u>BURIAL</u> 10/12/85                                    |   | 23c. NAME OF CEMETERY OR CREMATORIAL<br><u>GATE OF HEAVEN</u>  |                                      |  | 23d. LOCATION<br>CITY OR TOWN                                |   |          |       |
|  |  |   |  |   |  |                                      |  | COUNTY   |   |          |       |
| 24. FUNERAL DIRECTOR<br>NAME   |  |   | FRANCIS J. COLLINS, JR.<br>500 UNTV BLVD. W, SILVER SPRING, MD. 20901  |   | 25a. DATE REC'D. BY REGISTRAR<br><u>OCT 14 1985</u>  |                                      |  | 25b. REGISTRAR'S SIGNATURE<br><u>Francis J. Collins, Jr.</u> |   |          |       |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

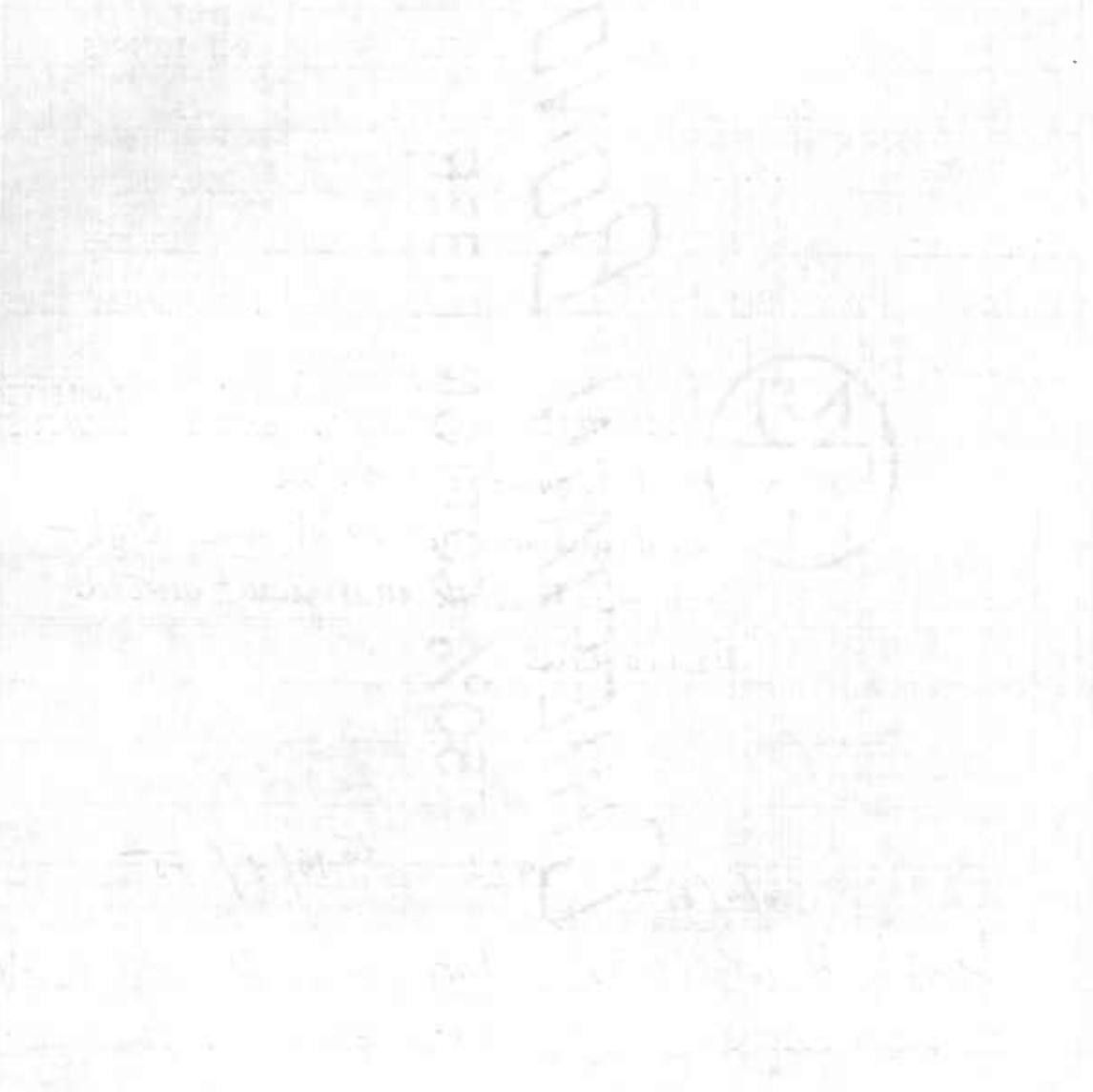
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, then please remove carbonbaggers. Pages 1 and 2 should be detached for use as the burial/transit permit. Then attach to burial or cremation permit with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked as 'No' show any injury, or other traumatic event, the medical examiner will be called.

BP \_\_\_\_\_

DHMH - 16 60M 7/84  
(VRA 15, 4)

101083



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

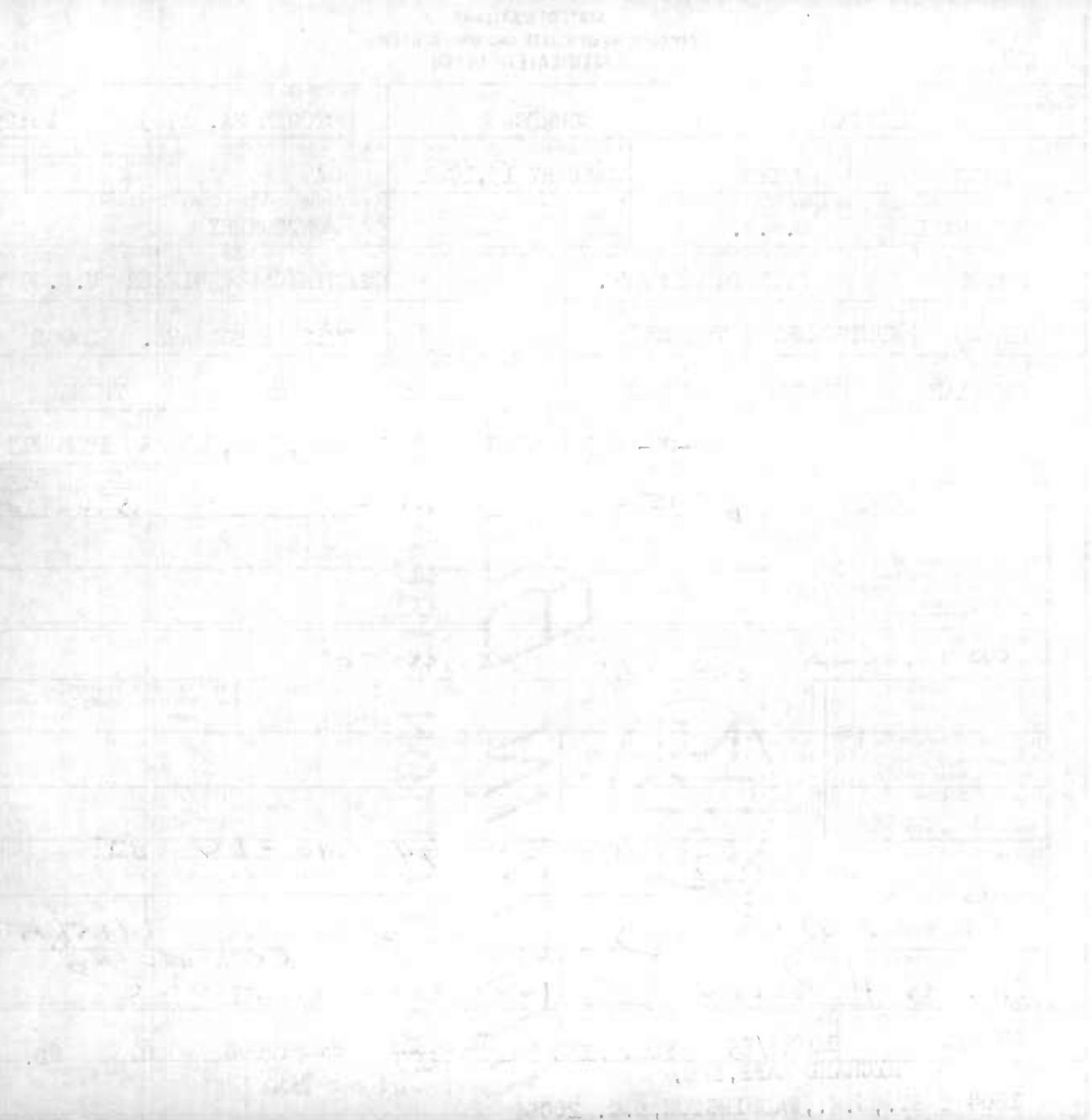
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

304151

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |                 |   |                   |  |       |  |      | 85 28 90  |  |
|--|--|---|-----------------|---|-------------------|--|-------|--|------|---|--|
| 1 - FOR<br>STATE<br>REGISTRAR  |  |   |                 |   |                   |  |       |  |      | REG. NO.  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST   | MIDDLE          | LAST  | 2a. DATE OF DEATH |  | MONTH | DAY  | YEAR | 2b. HOUR  |  |
| WILLIAM OPP COURSON  |  |   |                 |   | OCTOBER 24, 1985  |  |       |  |      | 10:25 PM  |  |
| 3. SEX   |  | 4. RACE   |                 | 5. DATE OF BIRTH  |                   | 6. AGE (IN YEARS LAST BIRTHDAY)  |       |  |      |   |  |
| MALE   |  | WHITE   |                 | MONTH DAY YEAR<br>JANUARY 15, 1901  |                   | IF UNDER 1 YEAR<br>MONTHS DAYS   |       | IF UNDER 24 HRS<br>HOURS MIN   |      |   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |                 | 8   |                   | MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |       | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY   |      | MD  |  |
| PENNSYLVANIA   |  | U.S.A.  |                 |   |                   |  |       |  |      |   |  |
| 10. CITY OR TOWN OF DEATH<br>WHEATON   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>2712 DAWSON AVE. |                 | 12a. USUAL OCCUPATION<br>LIVE OR WORK FOR PAY OR WORKING-CLASS INDUSTRY<br>ELECTRICAL ENGINEER  |                   | 12b. KIND OF BUSINESS OR<br>U.S.GOV'T.   |       |  |      |   |  |
| 13a. STATE<br>MARYLAND   |  | 13b. COUNTY<br>MONTGOMERY   |                 | 13c. CITY OR TOWN<br>WHEATON  |                   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |       | 13e. STREET ADDRESS<br>2712 DAWSON AVE. 20902  |      |   |  |
| 14. FATHER'S NAME<br>WILLIAM   |  | MIDDLE<br>MUSSER  | LAST<br>COURSON | 15. MOTHER'S MAIDEN NAME<br>ELIZABETH   |                   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |       | 16b. SOCIAL SECURITY NO.<br>161-09-9613  |      | 17. INFORMANT<br>RUTH GREEN COURSON, WIFE, SAME AS ITEM #13 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>BRAIN</u>  |  | DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____   |                 | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>5 months</u>  |                   |  |       |  |      |   |  |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause last   |  | DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |                 |   |                   |  |       |  |      |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>CARCINOMA</u> ✓ THE <u>Prostate</u>   |  |   |                 |   |                   |  |       |  |      |   |  |
| 20. MEDICAL CERTIFICATION  |  | 21. DATE OF OPERATION:  |                 | 22. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                   | 23. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |       | 24. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |      |   |  |
|  |  |   |                 |   |                   |  |       |  |      |   |  |
| 25. ACCIDENT WAS UNDERLYING<br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 26. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |                 | 27. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 26, PART 1 OR PART 2)  |                   |  |       |  |      |   |  |
| 28. INJURY OCCURRED<br>WHILE<br>AT HOME <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 29. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |                 | 30. LOCATION<br>STREET  |                   | CITY OR TOWN   |       | COUNTY   |      | STATE   |  |
| 31. I certify that (I) (this hospital) attended the deceased from<br>Nov 1974 to 10-24-85<br>saw the deceased alive on 10-24-85<br>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) did not view the body after death. |  |   |                 |   |                   |  |       |  |      |   |  |
| 32. SIGNATURE<br><u>Ruth Green</u>   |  | 33. DEGREE  |                 | 34. ATTENDING<br>PHYSICIAN <input checked="" type="checkbox"/> MEDICAL<br>DIRECTOR <input type="checkbox"/> STAFF<br>PHYSICIAN <input type="checkbox"/> |                   | 35. DATE SIGNED<br><u>10-25-85</u>   |       |  |      |   |  |
| 36. PHYSICIAN'S NAME<br>(TYPE OR PRINT)<br><u>Richard H. Green</u>   |  | 37. ADDRESS<br><u>10430 Concourse Ave</u>   |                 |   |                   |  |       |  |      |   |  |
| 38a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  | 38b. DATE<br>10/28/85   |                 | 38c. NAME OF CEMETERY OR CREMATORIAL<br>CEMETERY  |                   | 38d. LOCATION<br>CITY OR TOWN<br>BRENTWOOD   |       | 38e. COUNTY  |      | 38f. STATE  |  |
| 39. FUNERAL DIRECTOR<br>NAME<br>RICHARD RAPP, INC.<br>1804 T ST., N.W., WASHINGTON, D.C. 20009   |  |   |                 |   |                   | 40a. DATE REC'D. BY REGISTRAR<br>JUL 29 1985   |       | 40b. REGISTRAR'S SIGNATURE<br><u>BP</u>  |      | MD  |  |

11-1608



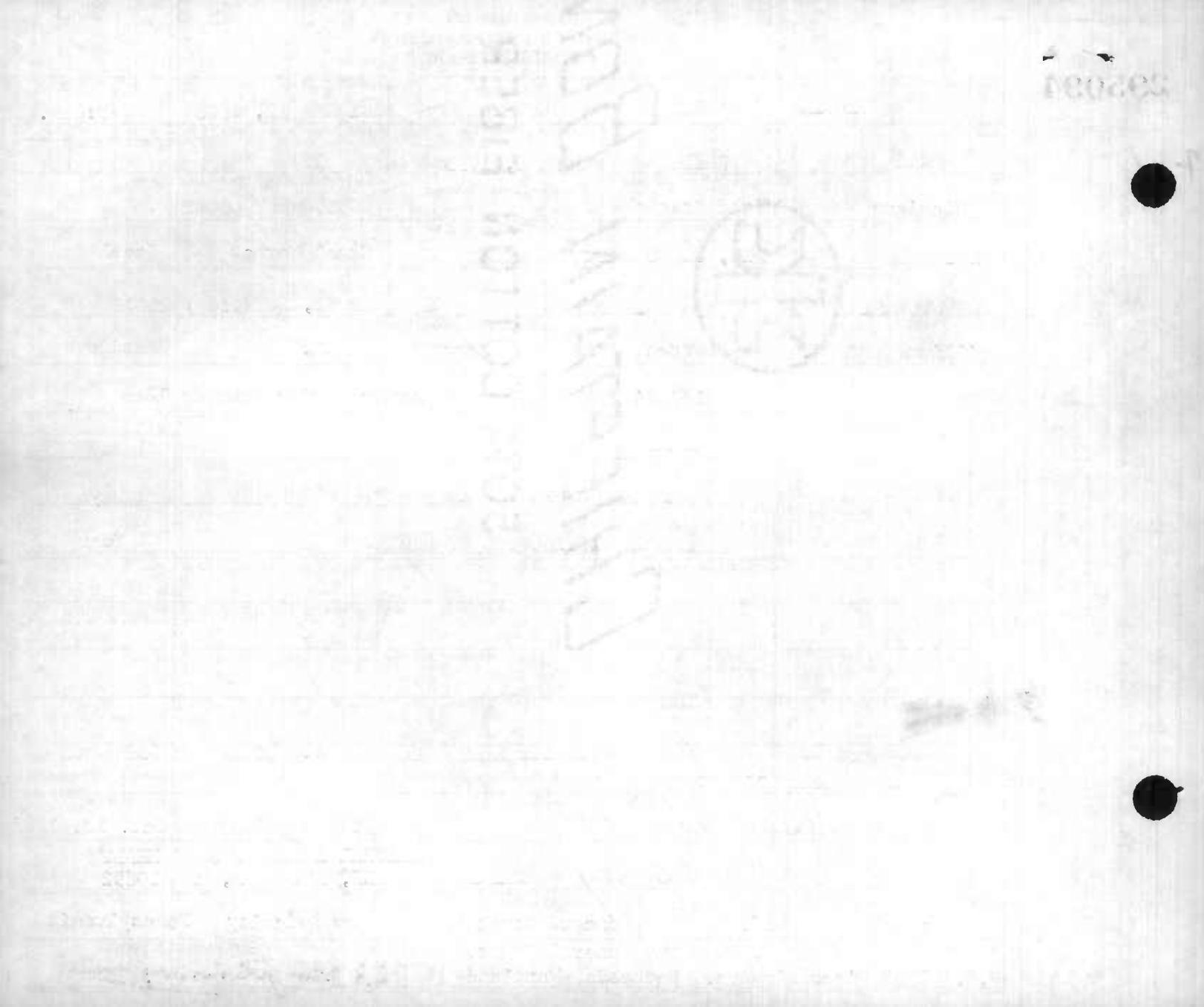
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with a signature retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 may be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 18 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be informed.)

295094

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |  |   |  |   |  |  |  | 8528991  |  |                               |  |          |  |  |  |
|--|--|---|--|--|--|---|--|---|--|--|--|--|--|-------------------------------|--|----------|--|--|--|
|  |  |   |  |  |  |   |  |   |  |  |  | REG. NO.   |  |                               |  |          |  |  |  |
| 1 - FOR STATE REGISTRAR  |  |   |  | 1 DECEASED NAME<br>(TYPE OR PRINT)   |  |   |  | LAST  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |                               |  | 2b. HOUR |  |  |  |
|  |  |   |  | WILLIAM JERRY COVATCH, Jr.   |  |   |  |   |  |  |  | OCTOBER 12, 1985   |  |                               |  | 7:01A.M. |  |  |  |
| 3 SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR   |  |   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>32 YRS                      |  |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS<br>HOURS MIN. |  |          |  |  |  |
| MALE   |  | WHITE   |  | JUNE 2, 1953   |  |   |  |   |  |  |  |  |  |                               |  |          |  |  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY COUNTY, MD. |  |  |  |  |  |                               |  |          |  |  |  |
| Michigan   |  | United States   |  |  |  |   |  |   |  |  |  |  |  |                               |  |          |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)              |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |                               |  |          |  |  |  |
| BETHESDA   |  | NIH, THE CLINICAL CENTER  |  |  |  | Steel Worker  |  |   |  | Steel  |  |  |  |                               |  |          |  |  |  |
| 13a. STATE<br>PENNSYLVANIA   |  | 13b. COUNTY<br>none   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  | 13e. STREET ADDRESS / ZIP CODE<br>RD #2, BOX #30 / 16115      |  |  |  | 99999  |  |                               |  |          |  |  |  |
| 14. FATHER'S NAME<br>William   |  | 15. MOTHER'S MAIDEN NAME<br>J. Covatch Sr.  |  | 15. MOTHER'S MAIDEN NAME<br>Nancy L. Restifo   |  |   |  |   |  |  |  |  |  |                               |  |          |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>175-44-2340   |  |  |  | 17. INFORMANT<br>Beverly Covatch wife same as 13e                             |  |   |  | ADDRESS  |  |  |  |                               |  |          |  |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for 1a, (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) SEPSIS  |  |   |  |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>1 Day   |  |                               |  |          |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) ACUTE BRONCHOPNEUMONIA   |  |   |  |  |  |   |  |   |  |  |  | 2 Days   |  |                               |  |          |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) DIFFUSE HISTIOCYTIC LYMPHOMA   |  |   |  |  |  |   |  |   |  |  |  | 1 Year   |  |                               |  |          |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a   |  |   |  |  |  |   |  |   |  |  |  |  |  |                               |  |          |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  |   |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                               |  |          |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |   |  |  |  |  |  |                               |  |          |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  |  |  | 21f. LOCATION<br>STREET   |  |   |  | CITY OR TOWN   |  | COUNTY   |  | STATE                         |  |          |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from November 6, 1984, to October 12, 1985, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on October 12, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) did <input type="checkbox"/> view the body after death. |  |   |  |  |  |   |  |   |  |  |  |  |  |                               |  |          |  |  |  |
| 22b. SIGNATURE<br>Joyce O'Shaughnessy, MD DEGREE<br>22c. DATE SIGNED<br>Oct. 13, 1985  |  |   |  |  |  |   |  |   |  |  |  |  |  |                               |  |          |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Joyce O'SHAUGHNESSY   |  | 22e. ADDRESS<br>NATIONAL INSTITUTES OF HEALTH<br>CLINICAL CENTER, BETHESDA, MD 20892                      |  |  |  |   |  |   |  |  |  |  |  |                               |  |          |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE Oct. 16, 1985   |  | 23c. NAME OF CEMETERY OR CREMATORIAL<br>Concord Cemetery   |  |   |  | 23d. LOCATION<br>CITY OR TOWN<br>New Swickley                 |  | COUNTY<br>Pennsylvania   |  |  |  |                               |  |          |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>P.A., 7557 Wisconsin Ave. Bethesda, Maryland   |  | Robert A. Pumphrey Funeral Homes,<br>ADDRESS  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 21 1985                                  |  | 25b. REGISTRAR'S SIGNATURE<br>John W. Parker                  |  |  |  |  |  |                               |  |          |  |  |  |



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - STATE  
REGISTRAR

|   |  |   |       |   |      |  |       |   |      |                 |  |
|---|--|---|-------|---|------|--|-------|---|------|-----------------|--|
| I. DECEASED NAME<br>(TYPE OR PRINT)   |  |   | FIRST | MIDDLE  | LAST | 2a. DATE OF DEATH  | MONTH | DAY   | YEAR | 2b. HOUR        |  |
| <b>PATRICIA M. COX</b>  |  |   |       |   |      | <b>OCT 20, 1985</b>  |       |   |      |                 |  |
| 3. SEX  |  | 4. RACE   |       | 5. DATE OF BIRTH<br>MONTH DAY YEAR  |      | 6. AGE (IN YEARS LAST BIRTHDAY)  |       | IF UNDER 1 YEAR   |      | IF UNDER 24 HRS |  |
| <b>FEMALE</b>   |  | <b>WHITE</b>  |       | <b>AUG 16, 1899</b>   |      | <b>86</b>  |       | MONTHS DAYS   |      | HOURS MIN.      |  |
| 7a. BIRTHPLACE<br>COUNTRY   |  | 7b. CITIZEN OF WHAT COUNTRY?  |       | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |      | 9. BALTIMORE CITY OR COUNTY OF DEATH   |       | MD.   |      |                 |  |
| <b>ALABAMA</b>  |  | <b>U. S. A.</b>   |       |   |      | <b>MONTGOMERY</b>  |       |   |      |                 |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |       |   |      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     |       | 12b. KIND OF BUSINESS OR INDUSTRY   |      |                 |  |
| <b>KENSINGTON</b>   |  | <b>CIRCLE MANOR NURSING HOME</b>  |       |   |      | <b>HAIR DRESSER</b>  |       | <b>OWNER</b>  |      |                 |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE ADDRESS BEFORE ADMISSION)   |  |   |       |   |      | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |       |   |      |                 |  |
| 13a. STATE  |  | 13b. COUNTY   |       | 13c. CITY OR TOWN   |      | 13e. STREET ADDRESS / ZIP CODE   |       |   |      |                 |  |
| <b>MARYLAND</b>   |  | <b>MONT.</b>  |       | <b>KENSINGTON</b>   |      | <b>10231 CARROLL PLACE</b>   |       |   |      |                 |  |
| 14. FATHER'S NAME<br>FIRST  |  | MIDDLE  |       | LAST  |      | 15. MOTHER'S MAIDEN NAME<br>FIRST  |       | MIDDLE  |      | LAST            |  |
| <b>JEREMIAH</b>   |  |   |       | <b>STUDSTILL</b>  |      | <b>ALICE</b>   |       | <b>V.</b>   |      | <b>KNOX</b>     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES OR NO UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.  |       | 17. INFORMANT   |      | ADDRESS  |       |   |      |                 |  |
| <b>NO</b>   |  | <b>261-20-2554</b>  |       | <b>JERRY S. PARR</b>  |      | <b>13640 GLENHEAST RD. TRAVILAH MD</b>   |       |   |      |                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>SENIILE INANITION</b>   |  |   |       |   |      | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>1 YEAR</b>                     |       |   |      |                 |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause last.<br>(b) _____<br>(c) _____   |  |   |       |   |      | DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>(c) _____                             |       |   |      |                 |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |       |   |      |  |       |   |      |                 |  |
| <b>CEREBROVASCULAR INSUFFICIENCY</b>  |  |   |       |   |      |  |       |   |      |                 |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |       |   |      | 20a. AUTOPSY?  |       | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |      |                 |  |
|   |  |   |       |   |      | YES <input type="checkbox"/> NO <input type="checkbox"/>                             |       | YES <input type="checkbox"/> NO <input type="checkbox"/>  |      |                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |      |  |       |   |      |                 |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |       | 21f. LOCATION<br>STREET   |      | CITY OR TOWN   |       | COUNTY  |      | STATE           |  |
| 22a. I certify that (in this hospital) attended the deceased from <b>3/20</b> , 19 <b>79</b> , to <b>10/20</b> , 19 <b>85</b> , that (I/we) last<br>saw the deceased alive on <b>10/19</b> , 19 <b>85</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I/we) did (did not) view the body after death. |  |   |       |   |      |  |       |   |      |                 |  |
| 22b. SIGNATURE<br><b>Martin C. Shargel</b>  |  | DEGREE<br><b>M.D.</b>   |       | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                          |      | 22c. DATE SIGNED<br><b>10/20/85</b>  |       |   |      |                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MARTIN C. SHARGEL</b>   |  | 22e. ADDRESS<br><b>3720 FAIRBOUT AVE.<br/>KENSINGTON, MD - 20895</b>                                      |       |   |      |  |       |   |      |                 |  |
| 23b. BURIAL, CREMATION, REMOVAL<br>ISPECIES   |  | 23c. NAME OF CEMETERY OR CREMATORIAL<br>REMOVED <b>REMOVED Cremation</b>                                  |       | 23d. LOCATION<br>CITY COUNTY STATE<br><b>MONTGOMERY ALABAMA</b>   |      |  |       |   |      |                 |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Takira Funeral Home, Inc.</b>  |  | ADDRESS<br><b>257 Carroll St. N.W.C.</b>  |       | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 23 1985</b>   |      | 25b. REGISTRAR'S SIGNATURE<br><b>Laura Davidson-Randall</b>                          |       |   |      |                 |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and solemnly filed in by the funeral director, please 3 should be detached for use as the burial/stainless permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or hospital, it should be detached for use as the burial/transit permit. Then please remove carbongraph paper. Page 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be signed by a physician.

281064

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |                                    |      |   |                                 |  |   | REG. NO.   |        |  |          |       |      |
|--|--|--|---|------------------------------------|------|---|---------------------------------|--|---|--|--------|--|----------|-------|------|
| 1. FOR<br>STATE<br>REGISTRAR   |  |  | 2. DATE OF DEATH  |                                    |      | MONTH   |                                 |  | DAY   |  | YEAR   | 2b HOUR  |          |       |      |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  | FIRST   | MIDDLE                             | LAST | August 4, 1985  |                                 |  | 12:00p  |  |        |  |          |       |      |
| 3. SEX   |  |  | 4. RACE   | 5. DATE OF BIRTH<br>MONTH DAY YEAR |      |   | 6. AGE (IN YEARS LAST BIRTHDAY) |  |   | IF UNDER 1 YEAR  |        | IF UNDER 24 HRS                                  |          |       |      |
| Male   |  |  | White   | August 4, 1901                     |      |   | 84                              |  |   | YRS  |        | MONTHS   | DAYS     | HOURS | MIN. |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)  |  |  | 7b. CITIZEN OF WHAT COUNTRY?  |                                    |      | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                 |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |        | V.D.K. Communications<br>INDUSTRY<br>CWA AFL CIO |          |       |      |
| Illinois   |  |  | USA   |                                    |      |   |                                 |  | Montgomery  |  |        | MD   |          |       |      |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                    |      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |                                 |  | 15107 Interlacher Drive   |  |        |  |          |       |      |
| Olney  |  |  | Montgomery General Hospital   |                                    |      | Sr. Executor  |                                 |  |   |  |        |  |          |       |      |
| 13a. STATE<br>Md.  |  |  | 13b. COUNTY<br>Mont.  |                                    |      | 13c. CITY OR TOWN<br>S.S.   |                                 |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               |  |        | 13e. STREET ADDRESS / ZIP CODE                   |          |       |      |
| 14. FATHER'S NAME<br>FIRST<br>William  |  |  | MIDDLE<br>Albert  |                                    |      | LAST<br>Crull   |                                 |  | 15. MOTHER'S MAIDEN NAME<br>FIRST<br>Pearl  |  |        | LAST<br>Duncan                                   |          |       |      |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |  | 16b. SOCIAL SECURITY NO.  |                                    |      | 17. INFORMANT   |                                 |  | ADDRESS   |  |        |  |          |       |      |
| None   |  |  | 511 05 6428A  |                                    |      | Ethel Crull (Wife) Same as 13E  |                                 |  |   |  |        |  |          |       |      |
| 18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>SEPTICEMIA</u>   |  |  |   |                                    |      |   |                                 |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>Days</u> |        |  |          |       |      |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause lost.   |  |  |   |                                    |      |   |                                 |  |   |  |        |  |          |       |      |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |  |   |                                    |      |   |                                 |  |   |  |        |  |          |       |      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>SHOCK, RESPIRATORY FAILURE</u>  |  |  |   |                                    |      |   |                                 |  |   |  |        |  |          |       |      |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                    |      | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                                 |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |        |  |          |       |      |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                                    |      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |                                 |  |   |  |        |  |          |       |      |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |                                    |      | 21f. LOCATION<br>STREET   |                                 |  | CITY OR TOWN  |  | COUNTY | STATE  |          |       |      |
| 22a. I certify that (I) <input type="checkbox"/> attended the deceased from <u>September 30, 1985</u> to <u>October 2, 1985</u> , that (I) <input type="checkbox"/> last<br>saw the deceased alive on <u>October 2, 1985</u> , and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated<br>above, (I) <input type="checkbox"/> did <input type="checkbox"/> not view the body after death. |  |  |   |                                    |      |   |                                 |  |   |  |        |  |          |       |      |
| 22b. SIGNATURE<br><u>Barry Hecht</u>   |  |  | DEGREE<br>M.D.  |                                    |      | ATTENDING<br>PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF<br>PHYSICIAN <input type="checkbox"/>                    |                                 |  | 22c. DATE SIGNED<br><u>October 2, 1985</u>  |  |        |  |          |       |      |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Barry Hecht, M.D.   |  |  | 22e. ADDRESS<br>3929 FERNARA DRIVE WHITSTON, MARYLAND 20802   |                                    |      |   |                                 |  |   |  |        |  |          |       |      |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |  | 23b. DATE<br>10/5/85  |                                    |      | 23c. NAME OF CEMETERY OR CREMATORIAL<br>Parklawn Cemetery   |                                 |  | 23d. LOCATION<br>CITY OR TOWN<br>Rockville  |  |        | COUNTY<br>Mont.                                  | MARYLAND |       |      |
| 24. FUNERAL DIRECTOR<br>Hines/Rinaldi 11800 New Hamp. Ave. S.S. Md.  |  |  |   |                                    |      | 25a. DATE REC'D. BY REGISTRAR<br>OCT 4 1985   |                                 |  | 25b. REGISTRAR'S SIGNATURE<br><u>Jane L. Johnson</u>  |  |        |  |          |       |      |
| BP   |  |  |   |                                    |      |   |                                 |  |   |  |        |  |          |       |      |
| DHMH - 16 60M 7/84<br>(VRA 15, 4)  |  |  |   |                                    |      |   |                                 |  |   |  |        |  |          |       |      |

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TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |  |  |   |  |  |   |  |  | 2 3 4 5 6 7 8 9 10 11 12  |  |  |   |  |  |   |  |                                  |                    |  |  |
|---|--|--|---|--|--|---|--|--|---|--|--|---|--|--|---|--|--|---|--|----------------------------------|--------------------|--|--|
|   |  |  |   |  |  |   |  |  |   |  |  | REG. NO.  |  |  |   |  |  |   |  |                                  |                    |  |  |
| 1. FOR<br>STATE<br>REGISTRAR  |  |  | 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  | FIRST<br>Mary   |  |  | MIDDLE<br>Louise  |  |  | LAST<br>Curtis  |  |  | 2a. DATE OF DEATH<br>MONTH<br>DAY<br>YEAR<br>10/11/85     |  |  | 2b. HOUR<br>1420 PM                       |  |                                  |                    |  |  |
| 3. SEX<br>Female  |  |  | 4. RACE<br>Caucasian  |  |  | 5. DATE OF BIRTH<br>MONTH<br>July   |  |  | DAY<br>6  |  |  | YEAR<br>1927  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>58                     |  |  | IF UNDER 1 YEAR<br>YRS.<br>MONTHS<br>DAYS |  | IF UNDER 24 HRS<br>HOURS<br>MIN. |                    |  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)<br>New York   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>United States   |  |  | 8. MARRIED<br>WIDOWED   |  |  | NEVER MARRIED<br>DIVORCED   |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County MD.   |  |  |   |  |  |   |  |                                  |                    |  |  |
| 10. CITY OR TOWN OF DEATH<br>Rockville  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SHADY GROVE AOK Hospital |  |  | 12a. USUAL OCCUPATION<br>Broker   |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>Real Estate   |  |  |   |  |  |   |  |  |   |  |                                  |                    |  |  |
| 13. STATE<br>Maryland   |  |  | 13b. COUNTY<br>Montgomery   |  |  | 13c. CITY OR TOWN<br>Germantown   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  | 13e. STREET ADDRESS<br>13004 Shadyside Lane/20874   |  |  |   |  |  |   |  |                                  |                    |  |  |
| 14. FATHER'S NAME<br>FIRST<br>Ralph   |  |  | MIDDLE<br>Thomas  |  |  | LAST<br>Curtis, Sr  |  |  | 15. MOTHER'S MAIDEN NAME<br>Eveline   |  |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(IF NO OR UNKNOWN) <input type="checkbox"/> (IF YES, GIVE WAR OR DATES)<br>NO            |  |  | 16b. SOCIAL SECURITY NO.<br>132-18-6829                   |  |  | 17. INFORMANT<br>Cynthia L. Royce         |  |                                  |                    |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <i>Cardiac Shock</i>   |  |  |   |  |  |   |  |  |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN COMET AND DEATH<br>24h  |  |  |   |  |  |   |  |                                  |                    |  |  |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause last<br>(b) <i>Myocardial infarction</i>  |  |  |   |  |  |   |  |  |   |  |  |   |  |  |   |  |  |   |  |                                  |                    |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>atherosclerosis</i>  |  |  |   |  |  |   |  |  |   |  |  |   |  |  |   |  |  |   |  |                                  |                    |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><i>Vasculitis</i>   |  |  |   |  |  |   |  |  |   |  |  |   |  |  |   |  |  |   |  |                                  |                    |  |  |
| 19. MEDICAL CERTIFICATION   |  |  | 20. DATE OF OPERATION   |  |  | 21. CONDITION FOR WHICH OPERATION WAS PERFORMED                                       |  |  | 22. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |  |  | 23. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |   |  |  |   |  |                                  |                    |  |  |
| 24. ACCIDENT WAS UNDERLYING<br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  |  | 25. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |  | 26. HOW INJURY OCCURRED<br>ENTER NATURE OF INJURY IN ITEMS 21-25. PART I, OR PART 25. |  |  |   |  |  |   |  |  |   |  |  |   |  |                                  |                    |  |  |
| 27. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  | 28. PLACE OF INJURY<br>AT HOME, STREET, FACTORY, OFFICE, PARK, ETC.   |  |  | 29. LOCATION<br>STREET  |  |  | 30. CITY OR TOWN  |  |  | 31. COUNTY  |  |  | 32. STATE   |  |  |   |  |                                  |                    |  |  |
| 27a. I certify that (i) (this hospital) attended the deceased from <i>10/11/85</i> to <i>10/11/85</i> , that (ii) (we) lost<br>saw the deceased alive on <i>10/11/85</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (If we) (and) (did not) view the body after death. |  |  |   |  |  |   |  |  |   |  |  |   |  |  |   |  |  |   |  |                                  |                    |  |  |
| 27b. SIGNATURE<br><i>D. Friedman</i>  |  |  |   |  |  |   |  |  |   |  |  | 33. DEGREE  |  |  | ATTENDING<br>PHYSICIAN                                    |  |  | MEDICAL<br>DIRECTOR                       |  |                                  | STAFF<br>PHYSICIAN |  |  |
| 28a. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Dennis Friedman</i>   |  |  |   |  |  |   |  |  |   |  |  | 34. ADDRESS<br>13-15 East Deer Park Dr, Gaithersburg MD   |  |  | 35. DATE SIGNED<br>10/11/85                               |  |  |   |  |                                  |                    |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation   |  |  | 23b. DATE<br>Oct.<br>13, 1985   |  |  | 23c. NAME OF CEMETERY OR CREMATORIAL<br>Metropolitan Crem.                            |  |  | 23d. LOCATION<br>CITY OR TOWN<br>Alexandria, Virginia   |  |  |   |  |  |   |  |  |   |  |                                  |                    |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Robert A. Pumphrey Funeral<br>Homes, P.A. Rockville, Maryland 20850   |  |  |   |  |  |   |  |  |   |  |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 16 1985  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>John Dennis Friedman</i> |  |  |   |  |                                  |                    |  |  |

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|--|--|---|-------|--|------|-------------------|---|-----------------|---|--|--------------|------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   | FIRST | MIDDLE   | LAST | 2a. DATE OF DEATH | MONTH   | DAY             | YEAR  | 2b. HOUR   |              |                  |  |
| FRANK C. DANIELS, SR.  |  |   |       |  |      | OCTOBER 19, 1985  |   |                 |   | 1:15 A M   |              |                  |  |
| 3. SEX   |  | 4. RACE   |       | 5. DATE OF BIRTH   |      |                   | 6. AGE (IN YEARS LAST BIRTHDAY)   |                 |   | 7. IF UNDER 1 YEAR                                   |              |                  |  |
| MALE   |  | CAUCASIAN   |       | MONTH  | DAY  | YEAR              | 73  | IF UNDER 24 HRS |   |  |              |                  |  |
| 7a. BIRTHPLACE<br>(COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |       | 8. MARRIED   |      |                   | MONTHS  |                 |   | DAYS   |              |                  |  |
| WASHINGTON, D.C.   |  | U.S.A.  |       | XX<br>MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |      |                   | YEARS   |                 |   | HOURS MIN.   |              |                  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |       |  |      |                   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |                 |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY                 |              |                  |  |
| SILVER SPRING  |  | 1902 DAYTON STREET  |       |  |      |                   | ENGINEER  |                 |   | FOOD &<br>DRUG ADMINISTRATI                          |              |                  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |       |  |      |                   |   |                 |   |  |              |                  |  |
| 13a. STATE<br>MARYLAND   |  | 13b. COUNTY<br>MONTGOMERY   |       | 13c. CITY OR TOWN<br>SILVER SPRING   |      |                   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                 | 13e. STREET ADDRESS / ZIP CODE<br>1902 DAYTON STREET 20902        |  |              |                  |  |
| 14. FATHER'S NAME<br>HARRY   |  | MIDDLE<br>J.  |       | LAST<br>DANIELS  |      |                   | 15. MOTHER'S MAIDEN NAME<br>FLOSSIE   |                 | ANN   |  |              | MIDDLE<br>BARNEY |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.<br>579-01-0119   |       | 16c. INFORMANT<br>IRENE S. DANIELS   |      |                   | 16d. ADDRESS<br>SAME AS 13  |                 |   | 16e. APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |              |                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiovascular collapse</u><br>{ DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>squamous cell carcinoma</u><br>{ DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>and pneumonia</u>                                   |  |   |       |  |      |                   |   |                 |   |  |              |                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.   |  |   |       |  |      |                   |   |                 |   |  |              |                  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |       |  |      |                   | 20a. AUTOPSY?   |                 | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH? |  |              |                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |      |                   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                             |                 | YES <input type="checkbox"/> NO <input type="checkbox"/>          |  |              |                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |       | 21f. LOCATION<br>STREET  |      |                   | CITY OR TOWN  |                 | COUNTY  |  | STATE        |                  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>AUGUST 1985</u> to <u>OCT. 21 1985</u> , that (I) (we) last saw the deceased alive on <u>OCT. 15 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |       |  |      |                   |   |                 |   |  |              |                  |  |
| 22b. SIGNATURE<br><u>José M. Solinas</u>   |  | 22c. DEGREE<br>MD   |       | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                |      |                   | 22e. DATE SIGNED<br><u>10/21/85</u>   |                 |   |  |              |                  |  |
| 22f. PHYSICIAN'S NAME<br>José M. SOLINAS, M.D.   |  | 22g. ADDRESS<br>980/GA AV. S. SP. MD. 20902   |       |  |      |                   |   |                 |   |  |              |                  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  | 23b. DATE<br>10/21/85   |       | 23c. NAME OF CEMETERY OR CREMATORIUM<br>FT. LINCOLN CEMETERY   |      |                   | 23d. LOCATION<br>CITY OR TOWN<br>BRENTWOOD  |                 | COUNTY<br>PRI GEO   |  | STATE<br>MD. |                  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>FRANCIS J. COLLINS, JR.  |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 23 1985  |       | 25b. REGISTRAR'S SIGNATURE<br><u>Francis J. Collins Jr.</u>  |      |                   |   |                 |   |  |              |                  |  |
| 500 UNTV. BLVD. W., SILVER SPRING, MD. 20901   |  |   |       |  |      |                   |   |                 |   |  |              |                  |  |

**TO HOSPITAL OR ATTENDING PHYSICIAN** The  
retained by the hospital or attending physician.

completely filled in by the funeral director, page 3 and 2 should be filled within 72 hours after death.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be signed by the hospital or attending physician.

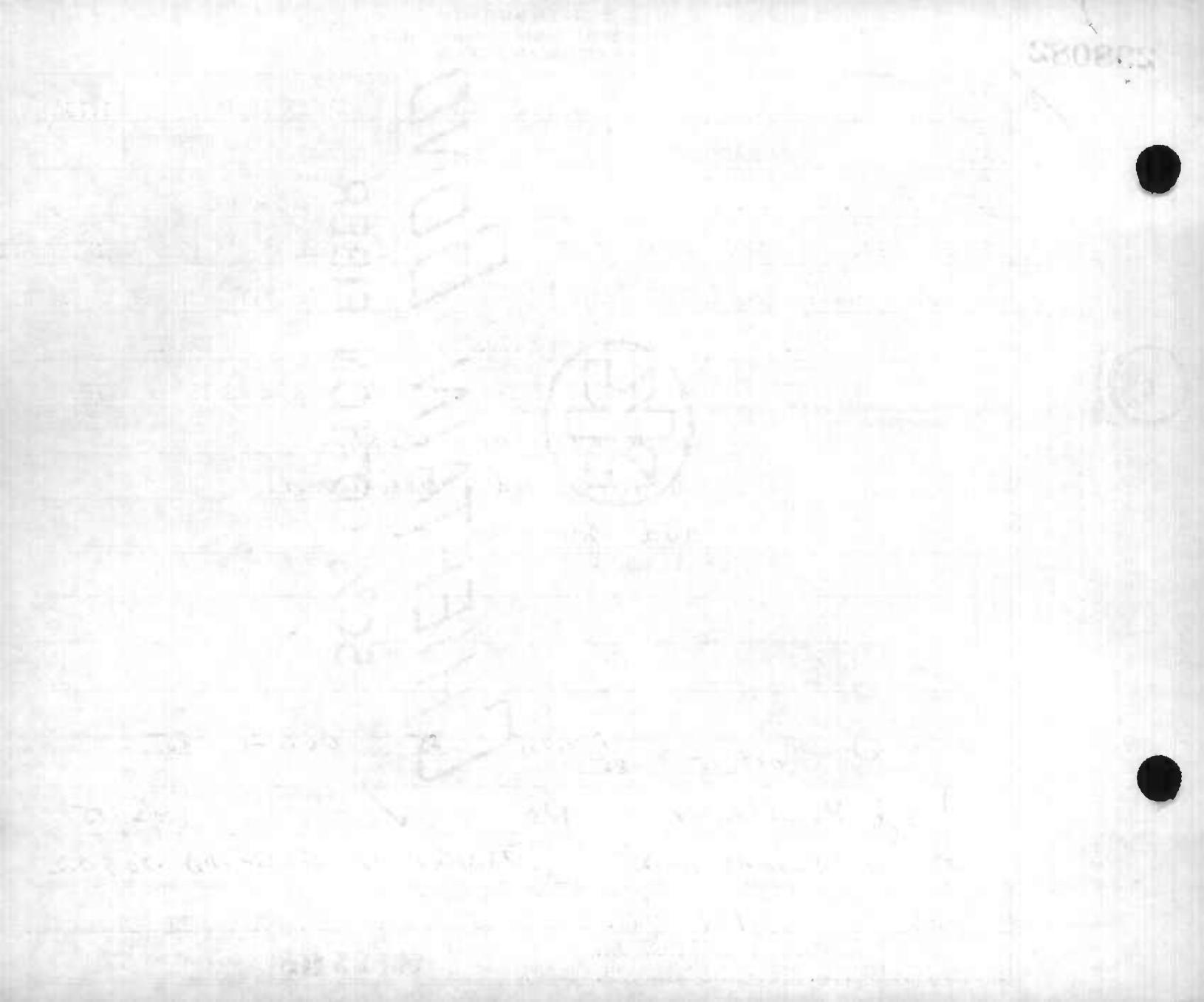
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If item 21 is mortared or item 18 shows any injury, or other traumatic event, the medical examiner must be consulted.

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(VRA 15-4)

DHMH - 16 60M 7/B4  
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

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REGISTRAR

|  |   |   |                          |   |   |  |   |                                |                             |  |   |   |  |                                      |  |
|--|---|---|--------------------------|---|---|--|---|--------------------------------|-----------------------------|--|---|---|--|--------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |   |   | FIRST                    | MIDDLE  | LAST  | 2a DATE OF DEATH   | MONTH   | DAY                            | YEAR                        | 2b HOUR  |   |   |  |                                      |  |
| <i>Lynn A. Daniels</i>   |   |   |                          |   |   | <i>10-29-1985</i>  |   |                                |                             | <i>10 14 AM</i>                                    |   |   |  |                                      |  |
| 3. SEX   | 4. RACE   | 5. DATE OF BIRTH  |                          |   | 6. AGE (IN YEARS LAST BIRTHDAY)                   | IF UNDER 1 YEAR  |   | IF UNDER 24 HRS                |                             |  |   |   |  |                                      |  |
| Female   | white   | MONTH   | DAY                      | YEAR  | 65  | MONTHS   | DAYS  | HOURS                          | MIN.                        |  |   |   |  |                                      |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                          |   | 9. BALTIMORE CITY OR COUNTY OF DEATH              | MD.  |   |                                |                             |  |   |   |  |                                      |  |
| Massachusetts  | USA   |   |                          |   | <i>Montgomery</i>                                 |  |   |                                |                             |  |   |   |  |                                      |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |                          |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR<br>INDUSTRY                              |                                |                             |  |   |   |  |                                      |  |
| <i>Silver Spring</i>   | <i>Stacy Cross Hospital</i>   |   |                          |   |   | <i>Ret. Secretary</i>  |   |                                |                             |  |   |   |  |                                      |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION) (GIVE RESIDENCE BEFORE ADMISSION)   |   |   |                          |   |   | 13a. STREET ADDRESS / ZIP CODE                                   |   |                                |                             |  |   |   |  |                                      |  |
| 13a. STATE   | 13b. COUNTY   | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS? |   |   | YES <input checked="" type="checkbox"/>                          | NO <input type="checkbox"/>                                       | 13e. STREET ADDRESS / ZIP CODE |                             |  |   |   |  |                                      |  |
| Maryland   | Montgomery  | Silver Spring   | 13d. INSIDE CITY LIMITS? |   |   | YES <input checked="" type="checkbox"/>                          | NO <input type="checkbox"/>                                       | 13e. STREET ADDRESS / ZIP CODE |                             |  |   |   |  |                                      |  |
| 14. FATHER'S NAME  | FIRST   | MIDDLE  | LAST                     | 15. MOTHER'S MAIDEN NAME  |   |  | FIRST   | MIDDLE                         | LAST                        |  |   |   |  |                                      |  |
|  | Harvey  |   | Stacy                    | <i>Lillian</i>  |   |  |   |                                | Lynn                        |  |   |   |  |                                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(IF YES, GIVE WAR OR DATES)  | N/A   | N/A   | 16b. SOCIAL SECURITY NO. | 17. INFORMANT   |   |  | ADDRESS   |                                |                             |  |   |   |  |                                      |  |
|  |   |   | 579-18-6186              | Thomas A. Daniels-husband-(same as 13e)                                       |   |  |   |                                |                             |  |   |   |  |                                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a)   |   |   |                          |   |   |  |   |                                |                             | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH    |   |   |  |                                      |  |
| <i>Cardiopulmonary arrest</i>  |   |   |                          |   |   |  |   |                                |                             | <i>24h</i>   |   |   |  |                                      |  |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause (b)  |   |   |                          |   |   |  |   |                                |                             | <i>Intracranial hemorrhage</i>                     |   |   |  |                                      |  |
| (b) <i>Intracranial hemorrhage</i>   |   |   |                          |   |   |  |   |                                |                             | <i>24h</i>   |   |   |  |                                      |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>Purpura</i> <i>Aneurysm</i>   |   |   |                          |   |   |  |   |                                |                             | <i>24h.</i>  |   |   |  |                                      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a   |   |   |                          |   |   |  |   |                                |                             |  |   |   |  |                                      |  |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |                          |   |   | 20a. AUTOPSY?  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH? |                                |                             |  |   |   |  |                                      |  |
|  |   |   |                          |   |   | YES <input type="checkbox"/>                                     | NO <input checked="" type="checkbox"/>                            | YES <input type="checkbox"/>   | NO <input type="checkbox"/> |  |   |   |  |                                      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR   |   |                          | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |   |  |   |                                |                             |  |   |   |  |                                      |  |
|  | P.M. 19   |   |                          |   |   |  |   |                                |                             |  |   |   |  |                                      |  |
| 21d. INJURY OCCURRED<br><br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |   |                          | 21f. LOCATION<br>STREET   |   |  | CITY OR TOWN  |                                | COUNTY                      |  | STATE   |   |  |                                      |  |
|  |   |   |                          |   |   |  |   |                                |                             |  |   |   |  |                                      |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Oct 28</i> , 1985, to <i>Oct 29</i> , 1985, that (I) (we) last<br>saw the deceased alive on <i>Oct 29/85</i> , 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) did (did not) view the body after death. |   |   |                          |   |   |  |   |                                |                             | 22b. DATE SIGNED<br><i>Oct 29/85</i>               |   |   |  |                                      |  |
| 22c. SIGNATURE<br><i>Octavio Polanco, Jr</i>   |   |   |                          |   |   |  |   |                                |                             | DEGREE   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> | MEDICAL DIRECTOR <input type="checkbox"/> | STAFF PHYSICIAN <input type="checkbox"/> | 22d. DATE SIGNED<br><i>Oct 29/85</i> |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>OCTAVIO POLANCO</i>  |   |   |                          |   |   |  |   |                                |                             | 22e. ADDRESS<br><i>5530 Wisconsin Ave. CC. Rd.</i> |   |   |  |                                      |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   | 23b. DATE   | 23c. NAME OF CEMETERY OR CREMATORIUM  |                          |   | 23d. LOCATION<br>CITY OR TOWN                     | COUNTY   |   | Md.                            |                             |  |   |   |  |                                      |  |
| Burial   | Nov. 1, 1985  | Parklawn Cemetery   |                          |   | Rockville   | Montgomery   |   |                                |                             |  |   |   |  |                                      |  |
| 24. FUNERAL DIRECTOR<br><i>Hines/Rinaldi Funeral Home</i>  | 11800 N.H. Ave.,<br>ADDRESS<br><i>Silver Spring, Md.</i>  |   |                          | 25a. DATE RECD. BY REGISTRAR<br><i>Oct 31 1985</i>                            | 25b. REGISTRAR'S SIGNATURE<br><i>John Rinaldi</i> |  |   |                                |                             |  |   |   |  |                                      |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it may be retained by the funeral director. Then please remember to send papers, Pages 1 and 2 should be held within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to Burial, Cremation or Removal.

REMARKS: If Item 23 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be called.

508043



TO HOSPITAL OR ATTENDING PHYSICIAN: After this certificate has been signed by the attending physician and completely informed by the funeral director page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper, pay your bill and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, file medical certification.

Cleared by Medical Examiner

BP \_\_\_\_\_

DHMH - 16 60M 7/84  
(VRA 15, 4)

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 28997

|  |  |  |   |  |  |  |  |      |   |  |                  |  |       |     |                                  |         |  |
|--|--|--|---|--|--|--|--|------|---|--|------------------|--|-------|-----|----------------------------------|---------|--|
| 1 - STATE<br>REGISTRAR   |  |  | REG. NO.  |  |  |  |  |      |   |  |                  |  |       |     |                                  |         |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT)   |  |  | FIRST   |  |  | MIDDLE   |  | LAST |   |  | 2a DATE OF DEATH |  | MONTH | DAY | YEAR                             | 2b HOUR |  |
| FREDERICK ARNOLD DAVIS, JR.  |  |  |   |  |  |  |  |      |   |  | 10-7-85          |  |       |     |                                  | 7:56 AM |  |
| 3. SEX   |  |  | 4. RACE   |  |  | 5. DATE OF BIRTH   |  |      | 6. AGE (IN YEARS LAST BIRTHDAY)   |  |                  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS                                |       |     | 8. IF UNDER 24 HRS<br>HOURS MIN. |         |  |
| MALE   |  |  | WHITE   |  |  | MONTH DAY YEAR   |  |      | 85  |  |                  |  |       |     |                                  |         |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |  | 7b CITIZEN OF WHAT COUNTRY?   |  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |      | 9 BALTIMORE CITY OR COUNTY OF DEATH   |  |                  | MD.  |       |     |                                  |         |  |
| VIRGINIA   |  |  | U.S.A.  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  |  |      | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |                  | 12b KIND OF BUSINESS OR INDUSTRY                                 |       |     |                                  |         |  |
| TAKOMA PARK  |  |  | WASHINGTON ADVENTIST HOSPT.   |  |  | 13. CITY OR TOWN   |  |      | RET-SALESMAN  |  |                  | INSURANCE CO.  |       |     |                                  |         |  |
| 14. SUEL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  | 15. STATE   |  |  | 16. COUNTY   |  |      | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |                  | 13e STREET ADDRESS / ZIP CODE                                    |       |     |                                  |         |  |
| Md.  |  |  | P.G.C.  |  |  | LANHAM   |  |      |   |  |                  | 4906 WEST LANHAM DR. 20784                                       |       |     |                                  |         |  |
| 17. FATHER'S NAME  |  |  | 18. MOTHER'S MAIDEN NAME  |  |  | 19. ADDRESS  |  |      | 20. APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |                  |  |       |     |                                  |         |  |
| FREDERICK  |  |  | ANNA  |  |  | L. HERNDON   |  |      | 614 SLIGO AVE.<br>SILVER SPRING, Md. 20910  |  |                  | 6 hours  |       |     |                                  |         |  |
| 21a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)   |  |  | 21b SOCIAL SECURITY NO.   |  |  | 21c INFORMANT  |  |      | 21d   |  |                  |  |       |     |                                  |         |  |
| NO   |  |  | 218-05-6244A  |  |  | ARNOLD B. LANHAM   |  |      |   |  |                  |  |       |     |                                  |         |  |
| 22a CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)   |  |  | 22b DUE TO, OR AS A CONSEQUENCE OF<br>(b)                             |  |  | 22c DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |      | 22d   |  |                  |  |       |     |                                  |         |  |
| Ruptured abdominal aortic aneurysm   |  |  | Diffuse atherosclerosis obliterans                                    |  |  |  |  |      | years   |  |                  |  |       |     |                                  |         |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a  |  |  |   |  |  |  |  |      |   |  |                  |  |       |     |                                  |         |  |
| 23a MEDICAL CERTIFICATION  |  |  | 23b DATE OF OPERATION   |  |  | 23c CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |      | 23d AUTOPSY?  |  |                  | 23e IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH? |       |     |                                  |         |  |
| 10.7.85  |  |  | Ruptured abdominal aortic aneurysm                                    |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |      | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |                  |  |       |     |                                  |         |  |
| 24a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  |  | 24b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |  | 24c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |      | 24d   |  |                  |  |       |     |                                  |         |  |
| 24e INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK  |  |  | 24f PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 24g LOCATION<br>STREET   |  |      | CITY OR TOWN  |  |                  | COUNTY STATE   |       |     |                                  |         |  |
| 24h I certify that (I) (this hospital) attended the deceased from 10.7.85 to 10.7.85, that (I) (we) last<br>saw the deceased alive on 10.7.85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  | 24i SIGNATURE   |  |  | 24j DEGREE   |  |      | 24k ATTENDING<br>PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF<br>PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |  |                  | 24l DATE SIGNED  |       |     |                                  |         |  |
| Sol Shatz  |  |  | M.D.  |  |  |  |  |      | 10.7.85   |  |                  |  |       |     |                                  |         |  |
| 24m PHYSICIAN'S NAME<br>(TYPE OR PRINT)  |  |  | 24n ADDRESS   |  |  | 24o LOCATION<br>CITY OR TOWN   |  |      | 24p COUNTY STATE  |  |                  |  |       |     |                                  |         |  |
| Sol Shatz  |  |  | 14524 CHESTERFIELD Rd.<br>Rockville Md. 20853                         |  |  | BRENTWOOD  |  |      | P.G.C.  |  |                  | Md.  |       |     |                                  |         |  |
| 24q BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  |  | 24r DATE  |  |  | 24s NAME OF CEMETERY OR CREMATORIUM  |  |      | 24t DATE REC'D. BY REGISTRAR  |  |                  | 24u REGISTRAR'S SIGNATURE  |       |     |                                  |         |  |
| BURIAL   |  |  | 10-10-1985  |  |  | FT. LINCOLN CEMETERY   |  |      | 10CT 14 1985  |  |                  | Gretchen Pendleton   |       |     |                                  |         |  |
| 24v FUNERAL DIRECTOR<br>NAME   |  |  | ADDRESS   |  |  | 24w RIVERDALE, Md. 20737   |  |      |   |  |                  |  |       |     |                                  |         |  |
| W. W. CHAMBERS CO.   |  |  |   |  |  |  |  |      |   |  |                  |  |       |     |                                  |         |  |

SEARCHED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial permit. Then please remove carbon paper, page 1 and 2 and be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or item 18 shows any injury, or other traumatic condition

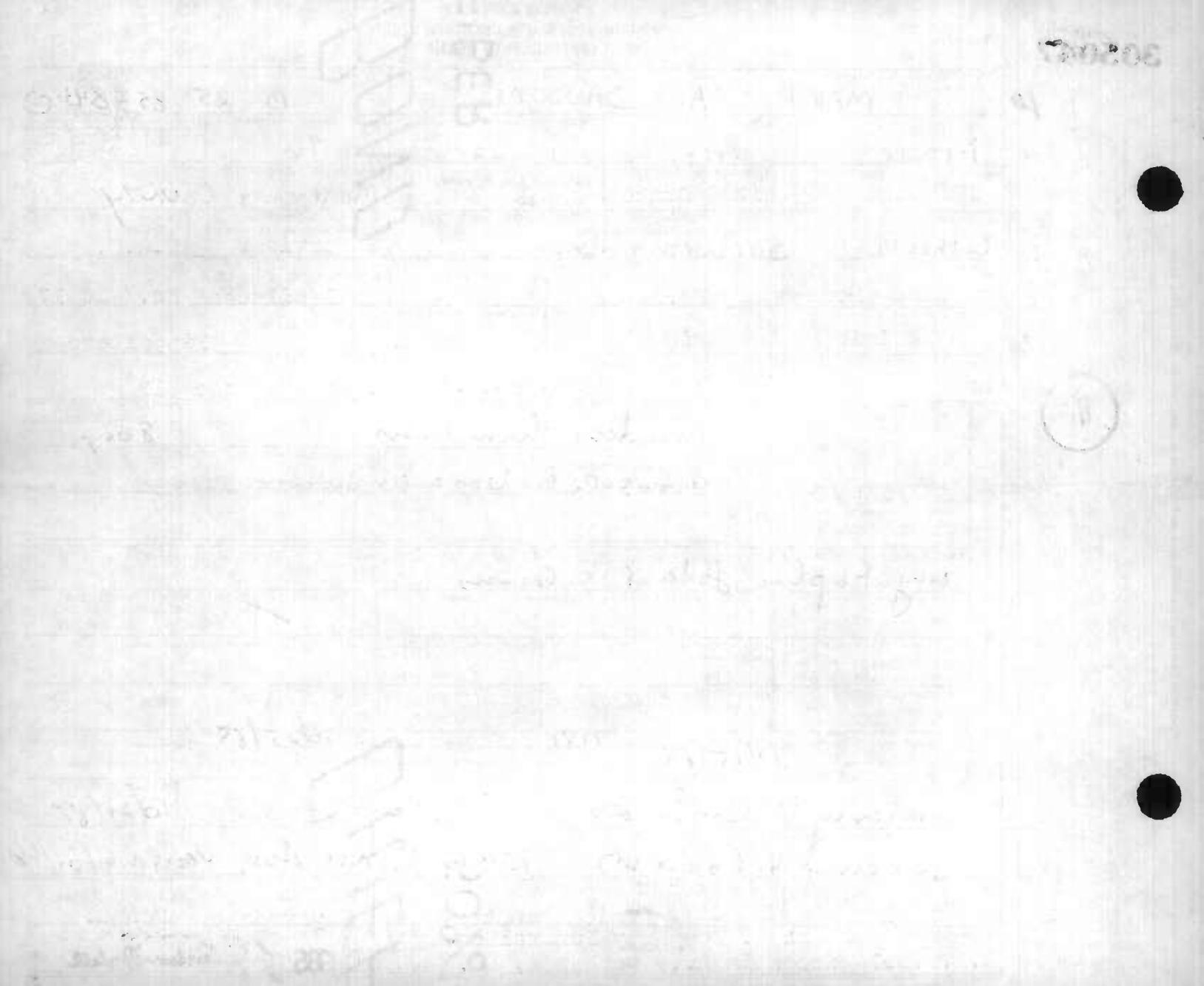
305047

FOR Film G612 Item 8  
1 - STATE 2/6/86 rjaSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |        |   |      |  |            |  |   |   |  |                              |
|---|--|---|--------|---|------|--|------------|--|---|---|--|------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   | FIRST  | MIDDLE  | LAST | 2a. DATE OF DEATH  | MONTH      | DAY  | YEAR  | 2b. HOUR                                  |  |                              |
| MARY  |  |   | A.     | DAWSON  |      | 10   | 25         | 85   | 8:43  |   |  |                              |
| 3. SEX  |  | 4. RACE   |        | 5. DATE OF BIRTH<br>MONTH DAY YEAR  |      | 6. AGE (IN YEARS LAST BIRTHDAY)  |            | IF UNDER 1 YEAR<br>MONTHS DAYS                           |   | IF UNDER 24 HRS<br>HOURS MIN.             |  |                              |
| Female  |  | White   |        | 11  | 22   | 08   | 76         | YRS  |   |   |  |                              |
| 7a. BIRTHPLACE<br>(COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |      | 9. BALTIMORE CITY OR COUNTY OF DEATH   |            |  |   |   |  |                              |
| New York  |  | United States   |        | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>         |      | Montgomery County  |            |  |   |   |  |                              |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |        | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                      |      | 12b. KIND OF BUSINESS OR INDUSTRY  |            |  |   |   |  |                              |
| Bethesda  |  | Surburban Hosp.   |        | Supervisor  |      | H.U.D.   |            |  |   |   |  |                              |
| 13a. STATE  |  | 13b. COUNTY   |        | 13c. CITY OR TOWN   |      | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |            | 13e. STREET ADDRESS / ZIP CODE                           |   |   |  |                              |
| Maryland  |  | Montgomery  |        | Bethesda  |      | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |            | 9521 Milstead Dr. / 20817                                |   |   |  |                              |
| 14. FATHER'S NAME<br>FIRST  |  | MIDDLE  | LAST   | 15. MOTHER'S MAIDEN NAME<br>FIRST   |      | MIDDLE   | LAST       |  |   |   |  |                              |
| Dominic   |  |   | Pisani | Rosina  |      |  | Pingnitaro |  |   |   |  |                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   |        | 17. INFORMANT   |      | ADDRESS  |            |  |   |   |  |                              |
| no  |  | 125 12 7161   |        | Frederick E. Dawson see #13   |      |  |            |  |   |   |  |                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) mesenteric thrombosis   |  |   |        |   |      |  |            | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>8 day |   |   |  |                              |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause lost<br>(b) arterosclerotic vascular disease  |  |   |        |   |      |  |            |  |   |   |  |                              |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |   |        |   |      |  |            |  |   |   |  |                              |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>anytopathic form of sclerosis   |  |   |        |   |      |  |            |  |   |   |  |                              |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |        | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |      | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |            |  |   |   |  |                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)         |      |  |            |  |   |   |  |                              |
| 21d. INJURY OCCURRED<br>WHITE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |        | 21f. LOCATION<br>STREET   |      | CITY OR TOWN   |            | COUNTY   |   | STATE                                     |  |                              |
| 22a. I certify that (I) (this hospital) attended the deceased from 1981, 19 to 10/25/85, 19, that (I) (we) last<br>saw the deceased alive on 10/25/85, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death |  |   |        |   |      |  |            |  |   |   |  |                              |
| 22b. SIGNATURE<br>Jeremy V. Cooke MD  |  |   |        |   |      |  |            | DEGREE   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> | MEDICAL DIRECTOR <input type="checkbox"/> | STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED<br>10/25/85 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS  |        |   |      |  |            |  |   |   |  |                              |
| Jeremy V. Cooke MD  |  | 10400 Conn. Ave., Kensington MD   |        |   |      |  |            |  |   |   |  |                              |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE October 31, 1985  |        | 23c. NAME OF CEMETERY OR CREMATORIAL<br>Union Cemetery                                |      | 23d. LOCATION CITY OR TOWN   |            | COUNTY   |   | STATE                                     |  |                              |
| Burial  |  |   |        |   |      | Meyersdale   |            | Penn.  |   |   |  |                              |
| 24. FUNERAL DIRECTOR<br>NAME Robert A. Pumphrey Funeral Home<br>ADDRESS P.A. 7557 Wisconsin Av., Bethesda, Md.  |  |   |        | 25a. DATE REC'D. BY REGISTRAR OCT 30 1985   |      | 25b. REGISTRAR'S SIGNATURE<br>Julie Davidson Pendleton   |            |  |   |   |  |                              |

1000000



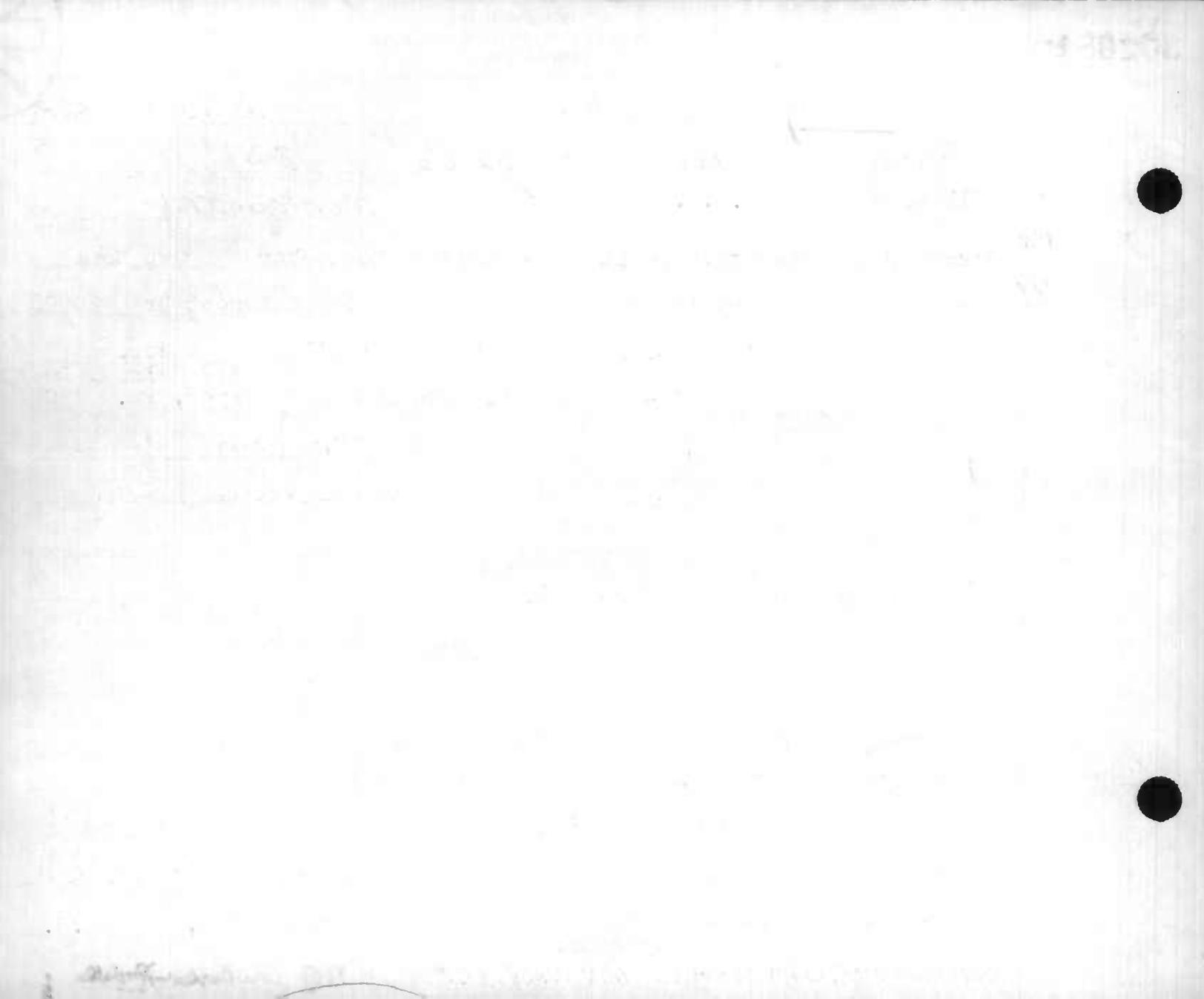
302081

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please return both pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as Item 18 above, any other information concerning the medical examiner must be notified in Part 1.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |  |  |   |  |  |  |  |  | 85 2899   |  |  |                 |      |                 |          |
|--|--|--|---|--|--|---|--|--|--|--|--|---|--|--|-----------------|------|-----------------|----------|
|  |  |  |   |  |  |   |  |  |  |  |  | REG. NO.  |  |  |                 |      |                 |          |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  | FIRST   |  |  | MIDDLE  |  |  | LAST   |  |  | 2d. DATE OF DEATH                                 |  |  | MONTH           | DAY  | YEAR            | 2b. HOUR |
| Dean; Elizabeth  |  |  |   |  |  |   |  |  |  |  |  | 10 15 85  |  |  |                 |      |                 | 1:32 PM  |
| 3. SEX   |  |  | RACE  |  |  | S. DATE OF BIRTH  |  |  | MONTH DAY YEAR   |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                   |  |  | IF UNDER 1 YEAR |      | IF UNDER 24 HRS |          |
| Female   |  |  | Cau.  |  |  | 2 22 03   |  |  |  |  |  | 82 YRS  |  |  | MONTHS          | DAYS | HOURS           | MIN.     |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN<br>TERRITORY)  |  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  |  | 8.  |  |  | MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH              |  |  | MD.             |      |                 |          |
| Illinois   |  |  | U.S.A.  |  |  |   |  |  |  |  |  | Montgomery  |  |  |                 |      |                 |          |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)              |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY   |  |  |   |  |  |                 |      |                 |          |
| Takoma Park  |  |  | Heritage Health Care Center   |  |  |   |  |  | Homemaker  |  |  | Own Home  |  |  |                 |      |                 |          |
| 13a. STATE   |  |  | 13b. COUNTY   |  |  | 13c. CITY OR TOWN   |  |  | 13d. INSIDE CITY LIMITS?   |  |  | 13e. STREET ADDRESS / ZIP CODE                    |  |  |                 |      |                 |          |
| Maryland   |  |  | Montgomery  |  |  | Silver Spring   |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  | 14658 Kelmscot Dr 20906                           |  |  |                 |      |                 |          |
| 14. FATHER'S NAME  |  |  | FIRST   |  |  | MIDDLE  |  |  | LAST   |  |  | 15. MOTHER'S MAIDEN NAME                          |  |  |                 |      |                 |          |
| William Fowler Mills Fetridge  |  |  |   |  |  |   |  |  |  |  |  | Alice Lucille Anderson                            |  |  |                 |      |                 |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |  | 16b. SOCIAL SECURITY NO.  |  |  | 17. INFORMANT   |  |  | ADDRESS  |  |  | 517 Colonel Dewee                                 |  |  |                 |      |                 |          |
| No   |  |  | 319-24-6867   |  |  | Elizabeth Wanderer Wayne, Pa. 19087   |  |  |  |  |  |   |  |  |                 |      |                 |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, b and c.)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Stroke</u> APPROXIMATE INTERVAL<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause, if any. <u>Cerebrovascular thrombosis</u><br>DUE TO, OR AS A CONSEQUENCE OF <u>Arteriosclerotic cardiovascular disease</u> BETWEEN ONSET AND DEATH<br>(b) <u>Arteriosclerotic cardiovascular disease</u> <u>20 days</u><br>(c) <u></u> |  |  |   |  |  |   |  |  |  |  |  |   |  |  |                 |      |                 |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.<br><u>Congestive heart failure</u>   |  |  |   |  |  |   |  |  |  |  |  |   |  |  |                 |      |                 |          |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?   |  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?  |  |  |   |  |  |                 |      |                 |          |
|  |  |  |   |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |   |  |  |                 |      |                 |          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |  | 21d. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  | 21e. LOCATION<br>STREET CITY OR TOWN COUNTY STATE |  |  |                 |      |                 |          |
| 21f. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>   |  |  |   |  |  |   |  |  |  |  |  |   |  |  |                 |      |                 |          |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death.  |  |  |   |  |  |   |  |  |  |  |  |   |  |  |                 |      |                 |          |
| 22b. SIGNATURE<br><u>B.P.J. Jones MD</u>   |  |  |   |  |  | DEGREE<br>MD  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  |  | 22e. DATE SIGNED<br>15 Oct 85                     |  |  |                 |      |                 |          |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT)<br>B.P.J. Jones MD   |  |  |   |  |  | 22d. ADDRESS<br>50 W Edmonson St. Baltimore Md                                |  |  |  |  |  |   |  |  |                 |      |                 |          |
| 23a. BURIAL, CREMATION, REMOVAL<br>LAW   |  |  | 23b. DATE<br>10-15-85   |  |  | 23c. NAME OF CEMETERY OR CREMATORIAL<br>Geo Wash Med School                   |  |  | 23d. LOCATION<br>CITY OR TOWN Washington, COUNTY D.C. STATE  |  |  |   |  |  |                 |      |                 |          |
| 24. FUNERAL DIRECTOR<br>NAME<br>COLUMBIA MORTUARY SERVICES   |  |  |   |  |  | 225 MISSOURI AVE,<br>ADDRESS  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>25b. REGISTRAR'S SIGNATURE<br>Julia Tridente  |  |  |   |  |  |                 |      |                 |          |
|  |  |  |   |  |  |   |  |  |  |  |  |   |  |  |                 |      |                 |          |



295163

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. PERTAINING 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 4 AND 5 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

ITEM NUMBER 4, PER FM CALL STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

29000

FOR  
STATE  
REGISTRAR

10-23,-85 D.W. DATE

REG. NO.

|   |                              |  |   |  |                                  |  |  |   |              |                      |                                      |   |  |
|---|------------------------------|--|---|--|----------------------------------|--|--|---|--------------|----------------------|--------------------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |                              |  |   | FIRST<br><b>PAVL</b>   | MIDDLE<br><b>LEONARD</b>         | LAST<br><b>DEIBEL</b>                              | 2a. DATE KNOWN<br>OF<br>ESTI-<br>DEATH MATED | MONTH<br>10   | DAY<br>05    | YEAR<br>1985         | 2b. HOUR<br>P M                      |   |  |
| 3. SEX  | 4. RACE                      | 5. DATE OF BIRTH<br>MONTH<br>DAY<br>YEAR | 6. AGE (IN YEARS<br>LAST BIRTHDAY)<br>YRS.  | IF UNDER 1 YR.<br>MONTHS<br>DAYS   | IF UNDER 24 HRS.<br>HOURS<br>MIN | 2c. DATE<br>PRONOUNCED<br>DEAD                     | MONTH<br>10                                  | DAY<br>07   | YEAR<br>1985 | 2d. HOUR<br>M        |                                      |   |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY? |  |   | 8. MARRIED<br>WIDOWED<br>DIVORCED  |                                  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH         |   |              |                      |                                      |   |  |
| Washington, D.C.  | U.S.A.                       |  |   |  |                                  |  | Montgomery                                   |   |              |                      |                                      |   |  |
| 10. CITY OR TOWN OF DEATH   |                              |  |   | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)  |              |                      | 12b. KIND OF BUSINESS<br>OR INDUSTRY |   |  |
| Bethesda  |                              |  |   | 5003 Wyandot Ct  |                                  |  |  | Estimator   |              |                      | Lumber                               |   |  |
| 13a. STATE  | 13b. COUNTY                  | 13c. CITY OR TOWN                        | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                                  |  | 13e. STREET ADDRESS                          |   |              |                      |                                      |   |  |
| MD  | Montgomery                   | Bethesda                                 | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                             |  |                                  |  | 5003 Wyandot Ct                              |   |              |                      |                                      |   |  |
| 14. FATHER'S NAME<br>FIRST<br><b>EDWARD</b>   |                              |  |   | MIDDLE<br><b>TILDEN</b>  | LAST<br><b>DEIBEL</b>            | 15. MOTHER'S MAIDEN NAME<br>FIRST<br><b>NELLIE</b> |  |   |              | MIDDLE<br><b>MAY</b> | LAST<br><b>WORTMAN</b>               |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)   |                              |  |   | 16b. SOCIAL SECURITY NO.   |                                  |  |  | 17. INFORMANT<br>ADDRESS  |              |                      |                                      |   |  |
| No  |                              |  |   | 579-30-5710  |                                  |  |  | SISTER-DOROTHY D. Lawson SAME AS #13  |              |                      |                                      |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a) stating the under-<br>lying cause last.<br>(b) <b>DIABETIC ACIDOSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>DIABETES MELLITUS</b> |                              |  |   |  |                                  |  |  |   |              |                      |                                      |   |  |
| APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>ACUTE</b>   |                              |  |   |  |                                  |  |  |   |              |                      |                                      |   |  |
| 2 - 3 DAYS  |                              |  |   |  |                                  |  |  |   |              |                      |                                      |   |  |
| INDOT   |                              |  |   |  |                                  |  |  |   |              |                      |                                      |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Depression</b> <b>Carcinoma</b> <b>Vaw</b> <b>Ethyanolism</b>   |                              |  |   |  |                                  |  |  |   |              |                      |                                      |   |  |
| 19a. DATE OF OPERATION  |                              |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |                                  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                           |              |                      |                                      |   |  |
| —   |                              |  |   | —  |                                  |  |  |   |              |                      |                                      |   |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                              |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>PM P.M. 10 5 1985                                       |                                  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>FOUND IN Bed                 |              |                      |                                      |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>  |                              |  |   | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)<br>Home                                     |                                  |  |  | 21f. LOCATION<br>STREET<br>5003 Wyandot Ct<br>CITY OR TOWN<br>Bethesda<br>COUNTY<br>Montgomery<br>STATE<br>MD |              |                      |                                      |   |  |
| 22a. I certify that I took charge of the remains described above, held on<br>death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>ACTUAL<br>SIGNATURE <i>Francis C. Mayle</i> TITLE (SPECIFY) <i>Dept</i> MEDICAL EXAMINER             |                              |  |   |  |                                  |  |  |   |              |                      |                                      |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |                              |  |   | 23b. DATE  |                                  |  |  | 23c. NAME OF CEMETERY OR CREMATORIAL<br>METROPOLITAN CEMETERY   |              |                      |                                      | 23d. LOCATION<br>CITY OR TOWN<br>ALEXANDRIA, VA |  |
| CREMATION OCT 8, 1985   |                              |  |   |  |                                  |  |  |   |              |                      |                                      | COUNTY<br>State                                 |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>James S. Bell - Denzel Funeral Home   |                              |  |   | 25a. DATE REC'D. BY REGISTRAR  |                                  |  |  | 25b. REGISTRAR'S SIGNATURE<br>OCT 15 1985 Julian G. Pendleton   |              |                      |                                      |   |  |
| WASHINGTON, D.C.  |                              |  |   |  |                                  |  |  |   |              |                      |                                      |   |  |
| 20M 4/B2  |                              |  |   |  |                                  |  |  |   |              |                      |                                      |   |  |
| DHMH - 17<br>(VR A15 ME (5))  |                              |  |   |  |                                  |  |  |   |              |                      |                                      |   |  |



296164

85 29001

**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH**

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|   |  |  |   |        |  |   |                                   |                                      |   |                           |                          |   |  |
|---|--|--|---|--------|--|---|-----------------------------------|--------------------------------------|---|---------------------------|--------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  | FIRST   | MIDDLE | LAST   | 2a. DATE OF DEATH   | MONTH                             | DAY                                  | YEAR  | 2b. HOUR                  |                          |   |  |
|   |  |  | FRANCES   | JEAN   | DETTOR   | OCTOBER 16, 1985  |                                   |                                      | 3:00 a.m.   |                           |                          |   |  |
| 3. SEX  |  |  | 4. RACE   |        | 5. DATE OF BIRTH   |   |                                   |                                      |   |                           |                          |   |  |
| FEMALE  |  |  | WHITE   |        | MONTH APRIL  | DAY 23,   | YEAR 1931                         | 6. AGE (IN YEARS LAST BIRTHDAY)      |   | IF UNDER 1 YEAR<br>MONTHS | IF UNDER 24 HRS<br>HOURS |   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)   |  |  | 7b. CITIZEN OF WHAT COUNTRY?  |        | MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | WIDOWED <input type="checkbox"/>  | DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH |   |                           |                          |   |  |
| West Virginia   |  |  | U.S.ofA.  |        |  |   |                                   | MONTGOMERY COUNTY,<br>MD.            |   |                           |                          |   |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |        |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |                                   |                                      | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |                           |                          |   |  |
| BETHESDA  |  |  | CLINICAL CENTER (NIH)   |        |  | Nurse/Homemaker-Hosp./Home  |                                   |                                      |   |                           |                          |   |  |
| 13a. STATE<br>MARYLAND  |  |  | 13b. COUNTY<br>Charles  |        | 13c. CITY OR TOWN<br>LA PLATA  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   |                                      | 13e. STREET ADDRESS / ZIP CODE<br>STAR RT 5, BOX 5024 20646   |                           |                          |   |  |
| 14. FATHER'S NAME<br>FIRST Jesse MIDDLE Dillard LAST Pultz  |  |  | 15. MOTHER'S MAIDEN NAME<br>Lula Lee Davis  |        |  |   |                                   |                                      |   |                           |                          |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  |  | 16b. SOCIAL SECURITY NO.<br>235-46-0153   |        |  | 17. INFORMANT<br>DR. VERNON DETTOR (HUSBAND)  |                                   |                                      | ADDRESS<br>SAME AS ABOVE  |                           |                          |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |   |        |  |   |                                   |                                      |   |                           |                          | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF<br><b>BREAST CARCINOMA - METASTATIC</b>  |  |  |   |        |  |   |                                   |                                      |   |                           |                          |   |  |
| { (c) DUE TO, OR AS A CONSEQUENCE OF<br><b>BREAST CANCER</b>  |  |  |   |        |  |   |                                   |                                      |   |                           |                          |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a   |  |  |   |        |  |   |                                   |                                      |   |                           |                          |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |        |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                                   |                                      | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                           |                          |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |        |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)                   |                                   |                                      |   |                           |                          |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |        |  | 21f. LOCATION<br>STREET   |                                   |                                      | 21g. CITY OR TOWN   | 21h. COUNTY               | 21i. STATE               |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Sept 25, 1985</u> to <u>OCT. 16, 1985</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>OCT. 16, 1985</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> view the body after death. |  |  |   |        |  |   |                                   |                                      |   |                           |                          |   |  |
| 22b. SIGNATURE<br><u>DR. LASSAM, NORMAN</u>   |  |  |   |        |  |   |                                   |                                      |   |                           |                          | 22c. DEGREE                                     |  |
| ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  |  |   |        |  |   |                                   |                                      |   |                           |                          | 22d. DATE SIGNED                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  | 22e. ADDRESS  |        |  | NATIONAL INSTITUTES OF HEALTH<br>CLINICAL CENTER, BETHESDA, MD 20205                            |                                   |                                      |   |                           |                          |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  |  | 23b. DATE   |        |  | 23c. NAME OF CEMETERY OR CREMATORIAL  |                                   |                                      | 23d. LOCATION<br>CITY OR TOWN   |                           |                          |   |  |
| BURIAL  |  |  | 10/19/85  |        |  | United Methodist  |                                   |                                      | Dentsville Charles Md.  |                           |                          |   |  |
| 24. FUNERAL DIRECTOR<br>NAME  |  |  | ADDRESS   |        |  | 25a. DATE REC'D. BY REGISTRAR   |                                   |                                      | 25b. REGISTRAR'S SIGNATURE  |                           |                          |   |  |
| AREHART FUNERAL HOME, INC., LA PLATA, MD.   |  |  |   |        |  | OCT 21 1985   |                                   |                                      | <u>John Arehart-Pendleton</u>   |                           |                          |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be attached for use as the burial/transit permit. Then please remove carbon from this certificate and attach it to the burial/transit permit with the State Dept. of Health and Mental Hygiene prior to burial/cremation. A copy of this certificate should be retained by the funeral director for 2 years. If item 21 is marked or item 18 shows any injury, or other trauma, attach a medical certificate of causation.

134000

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288005

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85.29002

1 - STATE REGISTRAR

REG. NO.

|   |  |  |           |   |  |               |   |   |                                |       |                 |      |          |  |  |
|---|--|--|-----------|---|--|---------------|---|---|--------------------------------|-------|-----------------|------|----------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST FRANCIS  |           |   | LAST   |               |   | 2a. DATE OF DEATH   |                                | MONTH | DAY             | YEAR | 2b. HOUR |  |  |
|   |  | Ronald F. Diehl  |           |   |  |               |   |   |                                | 10    | 2               | 85   | 12:35AM  |  |  |
| 3. SEX  |  | 4. RACE  |           | 5. DATE OF BIRTH  |  |               | 6. AGE (IN YEARS LAST BIRTHDAY)   |   | IF UNDER 1 YEAR                |       | IF UNDER 24 HRS |      |          |  |  |
| MALE  |  | WHITE  |           | JAN 18 1939   |  |               | 46  |   | MONTHS DAYS                    |       | HOURS MIN.      |      |          |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |           | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |               | 9. BALTIMORE CITY OR COUNTY OF DEATH  |   | MD.                            |       |                 |      |          |  |  |
| MARYLAND  |  | USA  |           |   |  |               | Montgomery  |   | U.S. POST OFFICE               |       |                 |      |          |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                        |           |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     |               |   | 12b. KIND OF BUSINESS OR INDUSTRY   |                                |       |                 |      |          |  |  |
| Olney   |  | Montgomery General Hospital  |           |   | U.S. POST OFFICE   |               |   | MAIL DEL.   |                                |       |                 |      |          |  |  |
| 13a. STATE  |  | 13b. COUNTY  |           | 13c. CITY OR TOWN   |  |               | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE |       | 20853           |      |          |  |  |
| MARYLAND  |  | MONTGOMERY   |           | ROCKVILLE   |  |               |   |   | 13016 EVANSTON STREET          |       |                 |      |          |  |  |
| 14. FATHER'S NAME   |  | FIRST BERNARD  | MIDDLE F. | LAST DIEHL  | 15. MOTHER'S MAIDEN NAME   |               |   | 16. ADDRESS   |                                |       |                 |      |          |  |  |
|   |  |  |           |   | FIRST GENEVA   | MIDDLE SOWERS | LAST  | SUSAN DIEHL 13016 EVANSTON ST. ROCKVILLE MD.  |                                |       |                 |      |          |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR OATES)  |           |   | 17. INFORMANT  |               |   | 20853   |                                |       |                 |      |          |  |  |
| YES   |  | 1958-1962  |           |   | 220-32-4096  |               |   | SUSAN DIEHL 13016 EVANSTON ST. ROCKVILLE MD.  |                                |       |                 |      |          |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for item (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a))  |  | 18. CAUSE OF DEATH (Enter only one cause per line for item (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)) |           |   | DUE TO, OR AS CONSEQUENCE OF<br>(a) Hypoxia and acidosis                             |               |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>30 min   |                                |       |                 |      |          |  |  |
|   |  |  |           |   | DUE TO, OR AS CONSEQUENCE OF<br>(b) Pulmonary hemorrhage and infection               |               |   | 3 hours   |                                |       |                 |      |          |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |           |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |               |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                |       |                 |      |          |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |           |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)        |               |   |   |                                |       |                 |      |          |  |  |
| 21d. INJURY OCCURRED<br><input type="checkbox"/> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |           |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |               |   |   |                                |       |                 |      |          |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |           |   |  |               |   |   |                                |       |                 |      |          |  |  |
| 22b. SIGNATURE  |  | 22c. DEGREE  |           |   |  |               |   | 22d. DATE SIGNED  |                                |       |                 |      |          |  |  |
| <i>Jules R. Losboth</i>   |  | 22c. DEGREE<br><i>MD</i>   |           |   |  |               |   | OCT 2, 1985   |                                |       |                 |      |          |  |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |           |   |  |               |   | ROCKVILLE MD.   |                                |       |                 |      |          |  |  |
| JULES R. LOSBOTH  |  | MONTGOMERY CO. GENERAL HOSPITAL  |           |   |  |               |   |   |                                |       |                 |      |          |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE  |           | 23c. NAME OF CEMETERY OR CREMATORIAL  |  |               | 23d. LOCATION<br>CITY OR TOWN   |   | 23e. COUNTY                    |       | 23f. STATE      |      |          |  |  |
| BURIAL  |  | OCT 4, 1985  |           | ZION MEMORIAL PARK  |  |               | CUMBERLAND ALLEGANY MARYLAND  |   |                                |       |                 |      |          |  |  |
| 24. FUNERAL DIRECTOR  |  | 25a. DATE REC'D. BY REGISTRAR  |           |   | 25b. REGISTRAR'S SIGNATURE   |               |   |   |                                |       |                 |      |          |  |  |
| STILCOX-MERRITT FUNERAL SERVICE CUMBERLAND MD.  |  | OCT 9 1985   |           |   | <i>John Stilcoix</i>   |               |   |   |                                |       |                 |      |          |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be resigned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be attached for use as the burial permit. Then please return certificate to the funeral director. Pages 1 and 2 should be filed within 24 hours after death, with the State Dept. of Health and Mental Hygiene plus to burial, cremation, or other disposition.

IMPORTANT: If Item 21 is marked with an "X" it must be signed by the attending physician.

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COLLECTOR'S

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |   |       |   |        |   |       |   |         |                               |  |
|--|--|---|-------|---|--------|---|-------|---|---------|-------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   | FIRST | MIDDLE  | LAST   | 2a. DATE OF DEATH   | MONTH | DAY   | YEAR    | 2b. HOUR                      |  |
| Agnes  |  |   | May   |   | Diener | October 7, 1985   |       |   | 10:00pm |                               |  |
| 3. SEX   |  | 4. RACE   |       | 5. DATE OF BIRTH<br>MONTH DAY YEAR  |        | 6. AGE (IN YEARS LAST BIRTHDAY)   |       | IF UNDER 1 YEAR<br>MONTHS DAYS                                    |         | IF UNDER 24 HRS<br>HOURS MIN. |  |
| female   |  | Caucasian   |       | April 11, 1894  |        | 91  |       |   |         |                               |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |       | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |        | 9. BALTIMORE CITY OR COUNTY OF DEATH  |       | MD.   |         |                               |  |
| New York   |  | United States   |       |   |        | Montgomery County,  |       |   |         |                               |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |       | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |        | 12b. KIND OF BUSINESS OR INDUSTRY   |       |   |         |                               |  |
| Bethesda   |  | Fernwood Nursing Home   |       | Artist  |        | Self employed   |       |   |         |                               |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |       |   |        | Zip   |       |   |         |                               |  |
| 13a. STATE   |  | 13b. COUNTY   |       | 13c. CITY OR TOWN   |        | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |       | 13e. STREET ADDRESS / ZIP CODE                                    |         | 20910                         |  |
| Maryland   |  | Montgomery  |       | Silver Spring   |        |   |       | 10000 Brunswick Ave #528  |         |                               |  |
| FATHER'S NAME<br>FIRST   |  | MIDDLE  | LAST  | 15. MOTHER'S MAIDEN NAME<br>FIRST   |        | Elizabeth   |       | Teresa  |         | LAST                          |  |
| Harry  |  |   | Stout | Rogers  |        |   |       |   |         |                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.  |       | 17. INFORMANT   |        | AD7200 Meadow Lane  |       |   |         |                               |  |
| No   |  | 157-30-1211   |       | Alberta D. McCormack  |        | Chevy Chase, Md. 20815  |       |   |         |                               |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)  |  |   |       |   |        | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>1 day  |       |   |         |                               |  |
| Intestinal Obstruction   |  |   |       |   |        |   |       |   |         |                               |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) Carcinoma of Stomach   |  |   |       |   |        | 1 year  |       |   |         |                               |  |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause lost<br>(c)  |  |   |       |   |        |   |       |   |         |                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>Senility   |  |   |       |   |        |   |       |   |         |                               |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |       |   |        | 20a. AUTOPSY?   |       | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH? |         |                               |  |
|  |  |   |       |   |        | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                             |       | YES <input type="checkbox"/> NO <input type="checkbox"/>          |         |                               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |        |   |       |   |         |                               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE FARM ETC.)   |       | 21f. LOCATION<br>STREET   |        | CITY OR TOWN  |       | COUNTY  |         | STATE                         |  |
| 22a. I certify that (I) (X) hospital attended the deceased from July 20, 1984, to October 2, 1985, that (I) (X) lost<br>sight in deceased alive on October 2, 1985, and that in (my) (X) opinion death occurred on the date and hour and from the causes stated<br>(X) (I did not) (X) (did not) view the body after death |  |   |       |   |        |   |       |   |         |                               |  |
| 27. SIGNATURE<br><i>Horace W. Bernton</i>  |  |   |       |   |        | 22c. DATE SIGNED<br>10-8-85   |       |   |         |                               |  |
| 27. (IAN'S NAME) (TYPE OR PRINT)<br>Horace W. Bernton, MD  |  |   |       |   |        | 28. ADDRESS<br>4743 Bradley Blvd., Chevy Chase, MD 20815  |       |   |         |                               |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 23b. DATE Oct. 8, 1985  |       | 23c. NAME OF CEMETERY OR CREMATORIAL<br>Metropolitan Crematory  |        | 23d. LOCATION<br>CITY OR TOWN Alexandria  |       | CITY OR TOWN  |         | COUNTY Virginia STATE         |  |
| Cremation  |  |   |       |   |        |   |       |   |         |                               |  |
| 24. FUNERAL DIRECTOR<br>NAME   |  | Robert A. Pumphrey Funeral<br>Adults<br>Homes, P.A. Bethesda, Maryland                                    |       |   |        | 25a. DATE REC'D. BY REGISTRAR<br>OCT 10 1985  |       | 25b. REGISTRAR'S SIGNATURE<br><i>Horace W. Bernton</i>            |         |                               |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be returned by the attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician it should be retained for use as the burial/transit permit. Then please remove carbon paper and mail with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If Item 21 is marked or Item 18 states any injury, or other traumatic event, the death certificate must be filed by the funeral director page 4 may be filed within 72 hours after death.

201803

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**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

REG. NO.

1 - STATE  
REGISTRAR

|  |              |  |   |                                     |   |  |       |  |                 |                 |       |  |
|--|--------------|--|---|-------------------------------------|---|--|-------|--|-----------------|-----------------|-------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |              |  | FIRST   | MIDDLE                              | LAST  | 2a DATE OF DEATH   | MONTH | DAY  | YEAR            | 2b HOUR         |       |  |
| <b>Barbara M. Dodd</b>   |              |  |   |                                     |   | <b>10 29 85</b>  |       |  |                 | <b>7 PM</b>     |       |  |
| 3 SEX  |              | 4 RACE   | 5. DATE OF BIRTH                              |                                     |   | 6. AGE (IN YEARS LAST BIRTHDAY)  |       |  | IF UNDER 1 YEAR |                 |       |  |
| <b>Female</b>  |              | <b>White</b>   | MONTH   | DAY                                 | YEAR  | <b>54</b>  | YRS   |  |                 | IF UNDER 24 HRS |       |  |
| 7a BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)   |              | 7b CITIZEN OF WHAT COUNTRY?  |   |                                     | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |       | 9. BALTIMORE CITY OR COUNTY OF DEATH   |                 |                 |       |  |
| <b>Wash.D.C.</b>   |              | <b>USA</b>   |   |                                     |   |  |       | <b>Montgomery</b>  |                 |                 |       |  |
| 10 CITY OR TOWN OF DEATH   |              | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF HOSPITAL, GIVE STATE OR PROVINCE) |   |                                     | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |       | 12b INDUSTRY   |                 |                 |       |  |
| <b>Bethesda</b>  |              | <b>Suburban Hospital</b>   |   |                                     |   |  |       | <b>Woodward &amp; Lothrop</b>  |                 |                 |       |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |              |  |   |                                     |   | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |       |  |                 |                 |       |  |
| 13a STATE  | 13b COUNTY   | 13c CITY OR TOWN   | 13e STREET ADDRESS / ZIP CODE                 |                                     |   |  |       |  |                 |                 |       |  |
| <b>Md.</b>   | <b>Mont.</b> | <b>S.S.</b>  | <b>2615 Weller Road 20901</b>                 |                                     |   |  |       |  |                 |                 |       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |              |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST |                                     |   |  |       |  |                 |                 |       |  |
| <b>Leroy W. Mason, Sr.</b>   |              |  | <b>Marabel Bradley</b>                        |                                     |   |  |       |  |                 |                 |       |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>None</b>   |              |  | 16b SOCIAL SECURITY NO.<br><b>217 32 0663</b> |                                     |   | 20d APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH  |       |  |                 |                 |       |  |
| PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a)   |              |  | 2302 Darrow St. S.S.Md.                       |                                     |   |  |       |  |                 |                 |       |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Hepatic Failure</b>   |              |  |   |                                     |   | 4 months   |       |  |                 |                 |       |  |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause, if any  |              |  |   |                                     |   |  |       |  |                 |                 |       |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |              |  |   |                                     |   |  |       |  |                 |                 |       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |              |  |   |                                     |   |  |       |  |                 |                 |       |  |
| 19a DATE OF OPERATION  |              | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |                                     | 20a AUTOPSY?  |  |       | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                 |                 |       |  |
| 21a ACCIDENT WAS UNDERLYING<br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |              | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   |                                     | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |       |  |                 |                 |       |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>   |              | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                            |   |                                     | 21f LOCATION<br>STREET  |  |       | CITY OR TOWN   |                 | COUNTY          | STATE |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>July 19 85</b> to <b>October 29 1985</b> , that (I) (we) last<br>saw the deceased alive on <b>October 29 1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death. |              |  |   |                                     |   |  |       |  |                 |                 |       |  |
| 22b SIGNATURE  |              | DEGREE   |   |                                     | ATTENDING<br>PHYSICIAN <input type="checkbox"/> MEDICAL<br>DIRECTOR <input type="checkbox"/> STAFF<br>PHYSICIAN <input type="checkbox"/>                    |  |       | 22c. DATE SIGNED   |                 |                 |       |  |
| <b>Christopher Linger</b>  |              |  |   |                                     |   |  |       | <b>10.30.85</b>  |                 |                 |       |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |              | 22e ADDRESS  |   |                                     |   |  |       |  |                 |                 |       |  |
| <b>Christopher Linger</b>  |              | <b>8218 Wisconsin Ave. Bethesda, Md.</b>   |   |                                     |   |  |       |  |                 |                 |       |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(TYPE OR PRINT)  |              | 23b DATE   |   | 23c NAME OF CEMETERY OR CREMATORIUM |   | 23d LOCATION   |       |  |                 |                 |       |  |
| <b>Burial</b>  |              | <b>11/1/85</b>   |   | <b>Colesville Cemetery</b>          |   | <b>Colesville Mont. Md.</b>  |       |  |                 |                 |       |  |
| 24 FUNERAL DIRECTOR<br>NAME  |              | ADDRESS  |   |                                     | 25a. DATE REC'D. BY REGISTRAR   |  |       | 25b. REGISTRAR'S SIGNATURE   |                 |                 |       |  |
| <b>Hines/Rinaldi</b>   |              | <b>11800 New Hamp. Ave. S.S.Md.</b>  |   |                                     | <b>OCT 31 1985</b>  |  |       | <b>John Rinaldi</b>  |                 |                 |       |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the funeral director, page 3 should be detached for use as the Burial transit permit. Then please return carbon copy pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or other final disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

302040



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8529005

1 - FOR  
STATE  
REGISTRAR

291081X

|   |  |   |        |  |       |   |       |  |      |                 |  |
|---|--|---|--------|--|-------|---|-------|--|------|-----------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   | FIRST  | MIDDLE   | LAST  | 2a DATE OF DEATH  | MONTH | DAY  | YEAR | 2b HOUR         |  |
| Charles   |  |   | Robert |  | Doner | 10-14-85  |       |  |      | 5 A.M.          |  |
| 3. SEX  |  | 4 RACE  |        | 5 DATE OF BIRTH<br>MONTH DAY YEAR  |       | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |       | IF UNDER 1 YEAR  |      | IF UNDER 24 HRS |  |
| Male  |  | Caucasian   |        | November 26, 1921  |       | 63  |       | MONTHS DAYS  |      | HOURS MIN       |  |
| 7a BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRIES)  |  | 7b CITIZEN OF WHAT COUNTRY?   |        | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |       | 9 BALTIMORE CITY OR COUNTY OF DEATH                                 |       | County,<br>Montgomery<br>MD.   |      |                 |  |
| Vermont   |  | United States   |        |  |       |   |       |  |      |                 |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |        | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |       | 12b KIND OF BUSINESS OR<br>INDUSTRY                                 |       |  |      |                 |  |
| Bethesda  |  | Suburban Hospital   |        | Painter  |       | Painting  |       |  |      |                 |  |
| 13a STATE   |  | 13c CITY OR TOWN  |        | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |       | 13e STREET ADDRESS / ZIP CODE                                       |       | 99999  |      |                 |  |
| Virginia  |  | Manassas  |        | YES <input checked="" type="checkbox"/>  |       | 9717 Brent Street   |       | 22110  |      |                 |  |
| 14. FATHER'S NAME<br>FIRST  |  | MIDDLE  |        | LAST   |       | 15. MOTHER'S MAIDEN NAME<br>FIRST                                   |       | MIDDLE   |      | LAST            |  |
| Alfred  |  |   |        | Doner  |       | Katherine   |       |  |      | Donnah          |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b SOCIAL SECURITY NO.   |        | 17. INFORMANT  |       | ADDRESS   |       | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH  |      |                 |  |
| No  |  | 008-12-5284   |        | Mr. Kenneth L. Doner, Brother, Same as #13   |       |   |       | 45 min   |      |                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Ventricular Fibrillation   |  |   |        |  |       |   |       |  |      |                 |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) Acute true posterior myocardial infarction  |  |   |        |  |       |   |       |  |      |                 |  |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause last  |  |   |        |  |       |   |       |  |      |                 |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |   |        |  |       |   |       |  |      |                 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |        |  |       |   |       |  |      |                 |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |        |  |       | 20a AUTOPSY?  |       | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |      |                 |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |        | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |       | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |       |  |      |                 |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                     |        | 21f LOCATION<br>STREET   |       | CITY OR TOWN  |       | COUNTY   |      | STATE           |  |
| 22a I certify that (I) (this hospital) attended the deceased from Oct. 9, 1985, to Oct 14, 1985, that (I) (we) lost<br>saw the deceased alive on above, (I) (we) (did) (did not) view the body after death. |  |   |        |  |       |   |       |  |      |                 |  |
| 22b SIGNATURE<br><i>Allen A. Nimetz</i>   |  | 22c DEGREE<br><i>M.D.</i>   |        | ATTENDING<br>PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF<br>PHYSICIAN <input checked="" type="checkbox"/>                   |       | 22d DATE SIGNED<br>10/14/85   |       |  |      |                 |  |
| 22e PHYSICIAN'S NAME (TYPE OR PRINT)<br>Allen A. Nimetz, M.D.   |  | 22e ADDRESS<br>5401 Western Avenue, N.W.<br>Washington, D.C. 20015  |        |  |       |   |       |  |      |                 |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation  |  | 23b DATE<br>October 15, 1985  |        | 23c NAME OF CEMETERY OR CREMATORIAL<br>Metropolitan Crematory  |       | 23d LOCATION<br>CITY OR TOWN<br>Alexandria, Virginia                |       | COUNTY STATE   |      |                 |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>P.A., 7557 Wisconsin Ave., Bethesda, MD. 20814   |  | 25a DATE REC'D. BY REGISTRAR<br>OCT 16 1985   |        | 25b REGISTRAR'S SIGNATURE<br><i>Julie Saidean Pendleton</i>  |       |   |       |  |      |                 |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and certified, it should be retained for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT) If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DHMH 16-80M 7/84  
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(VRA 15, 4)

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 29006

REG. NO.

|  |  |   |  |   |      |  |  |  |   |   |  |   |  |
|--|--|---|--|---|------|--|--|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   | FIRST  | MIDDLE  | LAST | 2a DATE OF DEATH   | MONTH  | DAY                                    | YEAR  | 2b HOUR   |  |   |  |
|  |  |   | <b>Genevieve Keeney DOODY</b>  |   |      | <b>October 12, 1985</b>  |  |  | <b>8:30 am</b>  |   |  |   |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR  |      |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |   |  |
| <b>Female</b>  |  | <b>White</b>  |  | <b>Nov. 2, 1918</b>   |      |  | <b>66</b>  |  |   |   |  |   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?                            |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |      |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |   | 10. CITY OR TOWN OF DEATH   |  |   |  |
| <b>Maryland</b>  |  | <b>U.S.A.</b>   |  |   |      |  | <b>Montgomery County, MD.</b>  |  |   | <b>Clarksburg</b>   |  |   |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  |  |   |  |   |      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |   |  |   |  |
| <b>22820 Timber Lake Lane</b>  |  |   |  |   |      | <b>Housewife</b>   |  |  | <b>Home</b>   |   |  |   |  |
| 13a. STATE<br><b>Maryland</b>  |  |   |  |   |      | 13b. COUNTY<br><b>Montgomery</b>   |  | 13c. CITY OR TOWN<br><b>Clarksburg</b> |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>22820 Timber Lake Lane / 20871</b> |  |
| 14. FATHER'S NAME<br>FIRST   |  |   | MIDDLE   |   |      | 15. MOTHER'S MAIDEN NAME<br>FIRST  |  |  | LAST  |   |  |   |  |
| <b>Ephriam</b>   |  |   | <b>Bilie</b>   |   |      | <b>Margaret</b>  |  |  | <b>Elizabeth Smith</b>  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES) |  | 17. INFORMANT   |      |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)) |  |   | ADDRESS   |  |   |  |
| <b>No</b>  |  | <b>None</b>   |  | <b>Boyd Doody, Clarksburg, Maryland 20871</b>   |      |  | <b>22820 Timber Lake Lane</b>  |  |   | <b>22 months</b>  |  |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |      | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 19, PART I OR PART 2)   |  |  |   |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>                                  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |      | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |   |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from<br>see the deceased alive on<br>above, (if live I did) (did not) view the body after death. |  |   | 22b. DATE  |   |      | 22c. DEGREE  |  |  | 22d. DATE SIGNED  |   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>James L. Hooper MD</b>   |  |   | 22e. ADDRESS<br><b>20877 15 East Deer Park Dr., Gaithersburg, Md.</b>  |   |      | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  | 22d. DATE SIGNED<br><b>10/15/85</b>   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  |   | 23b. DATE  |   |      | 23c. NAME OF CEMETERY OR CREMATORIUM   |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |   |  |   |  |
| <b>Burial</b>  |  |   | <b>Oct 15, 1985</b>  |   |      | <b>Mount Olivet Cemetery</b>   |  |  | <b>Frederick Frederick Md.</b>  |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Smith, Keeney and Basford Funeral Home</b><br>106 East Church Street, Frederick, Md. 21701                                     |  |   |  |   |      | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 21 1985</b>  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Schaeffer, B. J.</b>   |   |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attendant physician, it should be detached for use as the burial/transit permit. Then please remove carbon copy of page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove certificate from this page. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other trauma, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |        |   |   |                                      |  |   | 8529007                             |  |                   |   |      |  |
|---|--|--|---|--------|---|---|--------------------------------------|--|---|-------------------------------------|--|-------------------|---|------|--|
| 1 - STATE REGISTRAR   |  |  |   |        |   |   |                                      |  |   | REG. NO.                            |  |                   |   |      |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  | FIRST   | MIDDLE | LAST  | 2a. DATE OF DEATH   |                                      |  | MONTH   | DAY                                 | YEAR   | 2b. HOUR          |   |      |  |
| George William Douth  |  |  |   |        |   | October 18, 1985  |                                      |  |   |                                     |  | 5:45 a.m.         |   |      |  |
| 3. SEX  |  |  | 4. RACE   |        | 5. DATE OF BIRTH  |   | 6. AGE (IN YEARS LAST BIRTHDAY)      |  |   | IF UNDER 1 YEAR                     |  | IF UNDER 24 HRS   |   |      |  |
| Male  |  |  | White   |        | August 11, 1927   |   | 58                                   |  |   | MONTHS                              | YRS  | HOURS             | MIN.  |      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |  | 7b. CITIZEN OF WHAT COUNTRY?  |        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |   | MD.                                 |  |                   |   |      |  |
| New York, New York  |  |  | USA   |        |   |   | Montgomery County                    |  |   | Society Founder & President Webster |  |                   |   |      |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                       |        |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |                                      |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |                                     |  |                   |   |      |  |
| Bethesda  |  |  | NIH, The Clinical Center  |        |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                      |  | 20002 328 Massachusetts Ave, N. E.                                  |                                     |  |                   |   |      |  |
| 13a. STATE  |  |  | 13b. COUNTY   |        | 13c. CITY OR TOWN   |   | 13e. STREET ADDRESS / ZIP CODE       |  |   | G99717                              |  |                   |   |      |  |
| Washington  |  |  | N/A   |        | D. C.   |   |                                      |  |   |                                     |  |                   |   |      |  |
| 14. FATHER'S NAME   |  |  | FIRST   | MIDDLE | LAST  | 15. MOTHER'S MAIDEN NAME  |                                      |  | FIRST   | MIDDLE                              | LAST   | ADDRESS           |   |      |  |
| George  |  |  | -   |        | Douth   | Florence  |                                      |  | -   |                                     | Kamma  | Station, VA 22039 |   |      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |  | 16b. SOCIAL SECURITY NO.  |        |   | 17. INFORMANT   |                                      |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                     |                                     |  |                   |   |      |  |
| No  |  |  | 092-20-1646   |        |   | William D. Patkus   |                                      |  | Minutes   |                                     |  |                   |   |      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY.  |  |  | IMMEDIATE CAUSE (a) Cardio respiratory arrest   |        |   |   |                                      |  |   |                                     |  |                   |   |      |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  | DUE TO, OR AS A CONSEQUENCE OF<br>(b) Respiratory failure   |        |   |   |                                      |  |   |                                     |  |                   |   |      |  |
| {   |  |  | DUE TO, OR AS A CONSEQUENCE OF<br>(c) Pneumocystis/Acquired Immune Deficiency   |        |   |   |                                      |  |   |                                     |  |                   |   |      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.   |  |  |   |        |   |   |                                      |  |   |                                     |  |                   |   |      |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |        |   |   |                                      |  | 20a. AUTOPSY?   |                                     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                   |   |      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |        |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |                                      |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                     | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                   |   |      |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |        |   | 21f. LOCATION<br>STREET   |                                      |  | CITY OR TOWN  |                                     | COUNTY   |                   | STATE   |      |  |
| 22a. I certify that (I) (this hospital) attended the deceased from September 30, 1985, to October 18, 1985, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on October 18, 1985, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input type="checkbox"/> (not) view the body after death. |  |  |   |        |   |   |                                      |  |   |                                     |  |                   |   |      |  |
| 22b. SIGNATURE  |  |  | DEGREE  |        |   |   |                                      |  |   |                                     |  |                   | 22c. DATE SIGNED  |      |  |
| Dwaine R. Rieves MD   |  |  |   |        |   |   |                                      |  |   |                                     |  |                   | Oct. 18, 1985   |      |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |        |   |   |                                      |  |   |                                     |  |                   | 22e. ADDRESS  |      |  |
| Rieves, R. Dwaine   |  |  |   |        |   |   |                                      |  |   |                                     |  |                   | National Institutes of Health<br>Clinical Center, Bethesda, Md. 20892 |      |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  |  | 23b. DATE   |        |   | 23c. NAME OF CEMETERY OR CREMATORIUM  |                                      |  | 23d. LOCATION<br>CITY OR TOWN                                       |                                     |  | COUNTY            |   | SATE |  |
| Cremation   |  |  | 10-21-1985  |        |   | Lee's Crematory   |                                      |  | Washington, District of Columbia                                    |                                     |  |                   |   |      |  |
| 24. FUNERAL DIRECTOR<br>NAME  |  |  | 25a. DATE REC'D. BY REGISTRAR   |        |   |   |                                      |  |   |                                     |  |                   | 25b. REGISTRAR'S SIGNATURE  |      |  |
| J.Wm.Lee's Sons Co. 300-4th St., NE, Wash., DC 20002  |  |  | 29.1985   |        |   |   |                                      |  |   |                                     |  |                   | John Darden Jr.   |      |  |
| DHMH - 16 60M 7/84<br>(VRA 15, 4)   |  |  |   |        |   |   |                                      |  |   |                                     |  |                   |   |      |  |

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New York, New York

George Washington newspaper  
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Station, VA 22303  
Mills... same 1505-1507 Rd., Falls Church

George George  
Dorothy Dorothy

No

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Chemical Corporation, Division of Goodyear  
T. W. Tee's Game Co. 300-4th St., IL Map., DCCCS  
Chemical Corporation, Division of Goodyear  
10-21-1982 Tee's Chemicals

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please do.

retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Please send the original to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |                       |   |                  |  |                                 |   | REG. NO. 8529008                       |                                  |  |
|--|--|--|---|-----------------------|---|------------------|--|---------------------------------|---|--|----------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  | FIRST<br><b>BERNARD</b>   | MIDDLE<br><b>A.</b>   | LAST<br><b>DOWNEY</b>   | 2a DATE OF DEATH | MONTH<br><b>10</b>   | DAY<br><b>5</b>                 | YEAR<br><b>85</b>   | 2b HOUR<br><b>5:15 P.M.</b>            |                                  |  |
| 3. SEX   |  |  | 4. RACE   |                       | 5. DATE OF BIRTH<br>MONTH<br><b>11</b>  | DAY<br><b>8</b>  | YEAR<br><b>10</b>  | 6. AGE (IN YEARS LAST BIRTHDAY) |   | IF UNDER 1 YEAR<br>MONTHS<br><b>74</b> | IF UNDER 24 HRS<br>HOURS<br>MIN. |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN)   |  |  | 7b. CITIZEN OF WHAT COUNTRY?  |                       | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |                                 |   | MD.                                    |                                  |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                       |                       | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |                  | 12b. KIND OF BUSINESS OR INDUSTRY  |                                 |   |  |                                  |  |
| Takoma Park  |  |  | Washington Adventist Hospital   |                       | Plumber Retired   |                  | International  |                                 |   |  |                                  |  |
| 13a. STATE<br>Maryland   |  |  | 13b. COUNTY<br>Montgomery   |                       | 13c. CITY OR TOWN<br>Silver Spring  |                  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                                 | 14. STREET ADDRESS / ZIP CODE<br>708 Sherbrook Drive 20904  |  |                                  |  |
| 14. FATHER'S NAME<br>FIRST<br><b>Bernard</b>   |  |  | MIDDLE<br><b>A.</b>   | LAST<br><b>Downey</b> | 15. MOTHER'S MAIDEN NAME<br>FIRST<br><b>Margaret</b>  |                  | MIDDLE   |                                 | 16. LAST NAME<br><b>Costello</b>  |  |                                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>N/A</b>   |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE NUMBER OR DATES)<br><b>N/A 577-03-0845</b>  |                       | 17. INFORMANT<br>Minnie Downey-wife-(same as 13e)   |                  | ADDRESS  |                                 | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |                                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)                                |  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) |                       | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)                             |                  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)          |                                 | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) |  |                                  |  |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause lost   |  |  | DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Esophageal cancer</b>  |                       | DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |                  |  |                                 |   |  |                                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).                            |  |  |   |                       |   |                  |  |                                 |   |  |                                  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                       | 20a. AUTOPEX  |                  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                 |   |  |                                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)          |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |                  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                 |   |  |                                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                       | 21f. LOCATION<br>STREET   |                  | CITY OR TOWN   |                                 | COUNTY STATE  |  |                                  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from<br>above, (I) (we) (did) (did not) view the body after death.                               |  |  | 22b. DATE<br>10-9-1985  |                       | 22c. DEGREE   |                  | ATTENDING MEDICAL PHYSICIAN <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                                 |                                 | 22d. DATE SIGNED<br>10/5/85   |  |                                  |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  | 22f. ADDRESS<br>MARTIN J. NEUTZ 9525 Greenway Ln Suite greenbelt MD 20701   |                       |   |                  |  |                                 |   |  |                                  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  |  | 23b. DATE<br>Burial 10-9-1985   |                       | 23c. NAME OF CEMETERY OR CREMATORIAL<br>Gate of Heaven Cemetery   |                  | 23d. LOCATION<br>CITY OR TOWN<br>Silver Spring   |                                 | COUNTY STATE<br>Montgomery Md.  |  |                                  |  |
| 24. FUNERAL DIRECTOR<br>Kines/Rinaldi Funeral Home   |  |  | 25. ADDRESS<br>11800 N.H. Ave.,<br>Silver Spring, Md.   |                       | 25. DATE REC'D. BY REGISTRAR<br>OCT 7 1985  |                  | 25b. REGISTRAR'S SIGNATURE<br>J. DAVIDSON Rendee   |                                 |   |  |                                  |  |
| DHMH - 16 50M 4/83<br>(VRA 15, 4)  |  |  |   |                       |   |                  |  |                                 |   |  |                                  |  |

Original

**Cleared by Med. Examiner**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and returned by the hospital or attending physician.

TO BURIAL-TRANSIT PERMIT: Then please remove carbon paper. This form should be detached for use as the burial-transit permit. It may be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or shows any injury, or other traumatic event, the medical examiner must be notified.

**MEDICAL CERTIFICATION**

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |       |   |  |                   |   |   |       |   |   | 85 29 JUNY   |          |      |                                      |  |  |
|--|--|---|-------|---|--|-------------------|---|---|-------|---|---|--|----------|------|--------------------------------------|--|--|
|  |  |   |       |   |  |                   |   |   |       |   |   | REG. NO.   |          |      |                                      |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   | FIRST | MIDDLE  | LAST   | 2d. DATE OF DEATH |   |   | MONTH | DAY   | YEAR  | 2b. HOUR   |          |      |                                      |  |  |
| Stella MAE Draper  |  |   |       |   |  | 10 03 85          |   |   |       |   |   | 751 P M  |          |      |                                      |  |  |
| 3. SEX   |  | 4 RACE  |       | 5. DATE OF BIRTH  |  |                   | 6. AGE (IN YEARS LAST BIRTHDAY)   |   |       | 7. IF UNDER 1 YEAR                                  |   | 8. IF UNDER 24 HRS   |          |      |                                      |  |  |
| FEMALE   |  | White   |       | MONTH   | DAY  | YEAR              | 85  |   |       | MONTHS  | DAYS  | MONTHS   | HOURS    | MIN. |                                      |  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |       | 7c. MARRIED<br>WIDOWED  |  |                   | 7d. NEVER MARRIED<br>DIVORCED   |   |       | 9. BALTIMORE CITY OR COUNTY OF DEATH                |   |  | MD.      |      |                                      |  |  |
| VIRGINIA   |  | USA   |       |   |  |                   |   |   |       | Montgomery  |   |  |          |      |                                      |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)   |       |   |  |                   |   |   |       |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |          |      | 12b. KIND OF BUSINESS OR<br>INDUSTRY |  |  |
| Silver Spring  |  | Holy Cross Hospital   |       |   |  |                   |   |   |       |   |   | School Crossing Guard  |          |      | Public Schools                       |  |  |
| 13a. STATE   |  | 13b. COUNTY   |       | 13c. CITY OR TOWN   |  |                   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |       | 13e. STREET ADDRESS                                 |   |  | ZIP CODE |      |                                      |  |  |
| Maryland   |  | Montgomery  |       | Silver Spring   |  |                   |   |   |       | 9409 Baltimore Dr                                   |   |  | 20901    |      |                                      |  |  |
| 14. FATHER'S NAME<br>FIRST   |  | MIDDLE  |       | LAST  | 15. MOTHER'S MAIDEN NAME<br>FIRST  |                   |   | MIDDLE  |       | LAST  |   |  |          |      |                                      |  |  |
| William Curly  |  |   |       | Rock  | Mary Frances   |                   |   |   |       | Boher   |   |  |          |      |                                      |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | (IF YES, GIVE WAR OR DATES)   |       | 16b. SOCIAL SECURITY NO.  |  |                   | 17. INFORMANT   |   |       | 18. APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |   |  |          |      |                                      |  |  |
| NO   |  | None  |       | 218-20-1889   |  |                   | Donald Draper (Husband) SAME AS #13   |   |       |   |   |  |          |      |                                      |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>CARDIO-RESPIRATORY ARREST</u>   |  |   |       |   |  |                   |   |   |       |   |   |  |          |      |                                      |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u>   |  |   |       |   |  |                   |   |   |       |   |   |  |          |      |                                      |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost.<br>(c) DUE TO, OR AS A CONSEQUENCE OF  |  |   |       |   |  |                   |   |   |       |   |   |  |          |      |                                      |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a<br><u>OSTEOARTHRITIS, CHRONIC URINARY TRACT INFECTION</u>   |  |   |       |   |  |                   |   |   |       |   |   |  |          |      |                                      |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |       |   |  |                   |   |   |       | 20a. AUTOPSY?                                       |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |          |      |                                      |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |       |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                   |   | 22a. IF YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |       |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |          |      |                                      |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |       |   | 21f. LOCATION<br>STREET  |                   |   | CITY OR TOWN  |       |   | COUNTY STATE  |  |          |      |                                      |  |  |
| 22b. I certify that (I) (this hospital) attended the deceased from <u>Oct 2</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) <u>did not</u> view the body after death. |  |   |       |   |  |                   |   |   |       |   |   |  |          |      |                                      |  |  |
| 22b. SIGNATURE<br><u>Bernard A. Fitzgerald MD</u>  |  | 22c. DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |       |   | 22d. DATE SIGNED<br><u>10-4-85</u>   |                   |   |   |       |   |   |  |          |      |                                      |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>BERNARD A. FITZGERALD</u>  |  | 22e. ADDRESS<br><u>217 Univ. Blvd. East, Silver Spring, Md</u>  |       |   |  |                   |   |   |       |   |   |  |          |      |                                      |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><u>CREMATION</u>   |  | 23b. DATE<br><u>OCT. 8, 1985</u>  |       | 23c. NAME OF CEMETERY OR CREMATORIAL<br><u>CHAMBERS CREMATORIUM</u> |  |                   | 23d. LOCATION<br>CITY OR TOWN<br><u>RIVERDALE, P.G.C., MARYLAND</u>                             |   |       | 23e. STATE<br><u>20901</u>                          |   |  |          |      |                                      |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>CHAMBERS FUNERAL HOME</u>   |  | ADDRESS<br><u>SILVER SPRING, MD.</u>  |       |   | 25a. DATE REC'D. BY REGISTRAR<br><u>OCT 7 1985</u>                             |                   |   | 25b. REGISTRAR'S SIGNATURE<br><u>S. Davidson-Randall</u>                    |       |   |   |  |          |      |                                      |  |  |
| DHMH - 16 60M 7/84<br>(VRA 15, 4)  |  |   |       |   |  |                   |   |   |       |   |   |  |          |      |                                      |  |  |

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290021

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

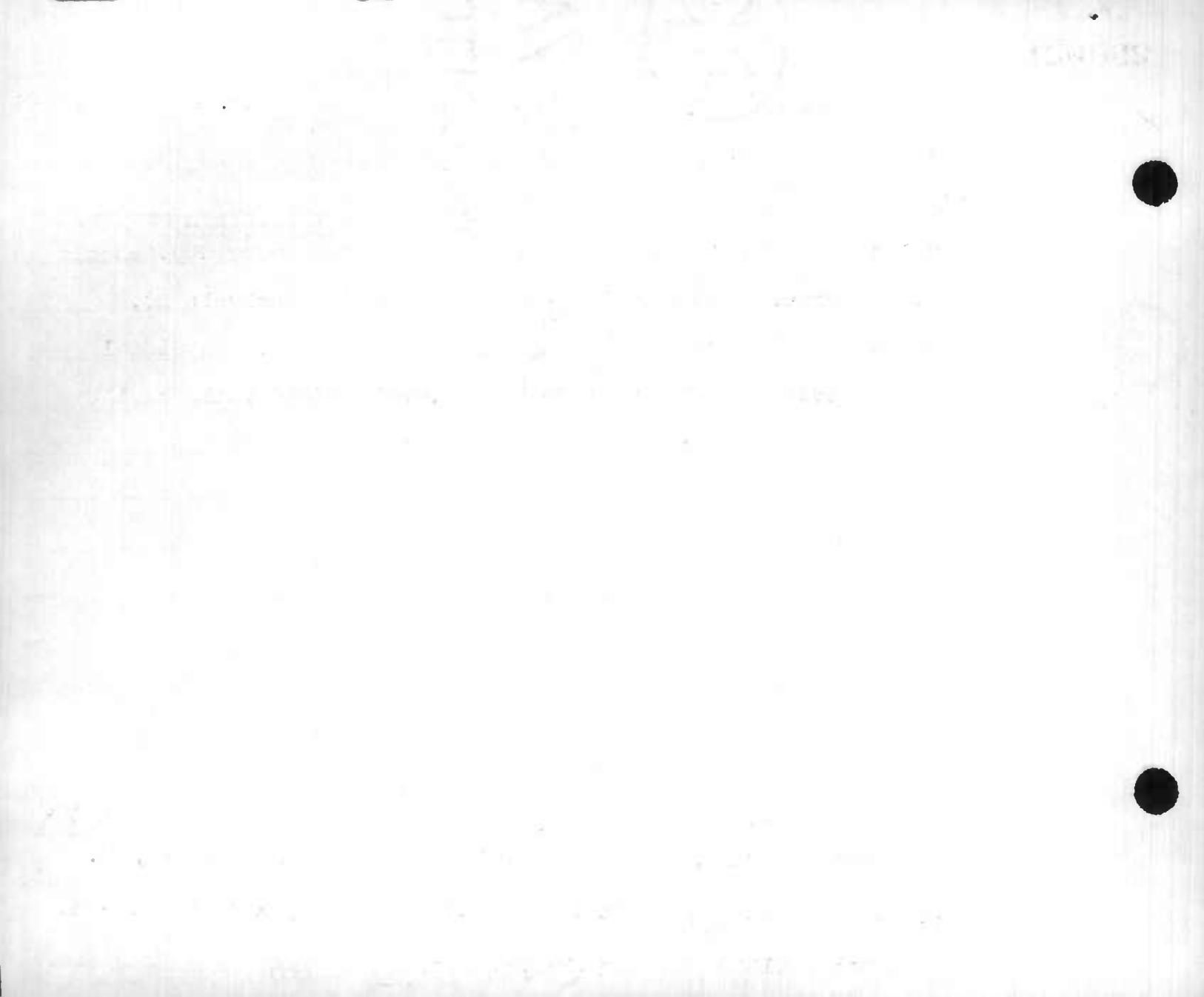
IMPORTANT: If Item 21 is marked as Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

85 29010

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |         |   |                                  |  |  |  |  |   |       |  |  |  |
|--|--|---|---------|---|----------------------------------|--|--|--|--|---|-------|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |         |   |                                  |  |  |  |  |   |       |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST   | MIDDLE  | LAST  | 2a. DATE OF DEATH MONTH DAY YEAR |  |  |  |  | 2b. HOUR  |       |  |  |  |
| Keith H.   |  |   | Dunlevy |   | Oct. 14 1985                     |  |  |  |  | 12:30PM   |       |  |  |  |
| 3. SEX   |  | 4. RACE   |         | 5. DATE OF BIRTH<br>MONTH DAY YEAR  |                                  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  |  |   |       | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |  |  |
| Male   |  | White   |         | July 28, 1929   |                                  |  | 56 YRS.  |  |  |   |       |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |         | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  |   |       | MD.  |  |  |
| Ohio   |  | USA   |         |   |                                  |  | Montgomery   |  |  |   |       |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |         | 12a. 12b. OCCUPATION<br>TYPE OF WORK, POSITION OR INDUSTRY  |                                  |  | 12c. 12d. STREET ADDRESS / ZIP CODE  |  |  |   |       |  |  |  |
| Rockville  |  | 14448 Parkvale Rd.  |         | Administrator   |                                  |  | Montgomery Cty. Schools  |  |  |   |       | 20863  |  |  |
| 13a. STATE   |  | 13b. COUNTY   |         | 13c. CITY OR TOWN   |                                  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                    |  |  |   |       | 13e. STREET ADDRESS / ZIP CODE               |  |  |
| Md.  |  | Mont.   |         | Rockville   |                                  |  |  |  |  |   |       | 14448 Parkvale Rd.                           |  |  |
| 14. FATHER'S NAME  |  | FIRST   | MIDDLE  | LAST  | 15. MOTHER'S MAIDEN NAME         |  |  |  |  | 16. APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |       |  |  |  |
| Charles  |  | K   | Dunlevy |   | Jane                             |  |  |  |  |   |       |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   |         | 17. INFORMANT   |                                  |  |  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) |   |       |  |  |  |
| Yes  |  | 1949  |         | Elva J. Dunlevy (Wife) Same as 13e  |                                  |  |  |  | Asiocarcinoma LUNG.  |   |       |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)   |  | DUE TO, OR AS A CONSEQUENCE OF<br>(b)   |         |   |                                  |  | DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |  |   |       |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |  |   |         |   |                                  |  |  |  |  |   |       |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |         |   |                                  |  |  |  |  |   |       |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |         |   |                                  |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>       |   |       |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |         | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                                  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |   |       |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)                                     |         | 21f. LOCATION<br>STREET   |                                  |  | CITY OR TOWN   |  | COUNTY   |   | STATE |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>saw the deceased alive on Oct 11 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death. |  | 22b. SIGNATURE<br><i>Pamula Mulshine</i>  |         | 22c. DEGREE<br><i>MD</i>  |                                  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22d. DATE SIGNED<br><i>10/14/85</i>  |   |       |  |  |  |
| 22e. ADDRESS<br>Pamula Mulshine, MD  |  | 22f. ADDRESS<br>10500 Summit Avenue, Kensington, Md.  |         |   |                                  |  |  |  |  |   |       |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>10/16/85   |         | 23c. NAME OF CEMETERY OR CREMATORIAL<br>Norbeck Mem. Gardens  |                                  |  | 23d. LOCATION<br>Olney   |  | 23e. STATE<br>Mont. Md.  |   |       |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Hines/Rinaldi  |  | ADDRESS<br>11800 New Hamp.Ave.S.S.Md.   |         | 25a. DATE REC'D. BY REGISTRAR<br>OCT 15 1985  |                                  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Jane Davidson Rendell</i>   |  |  |   |       |  |  |  |



299177

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8529011

REG. NO.

1 - STATE  
REGISTRAR

|   |  |   |  |                   |  |  |       |        |   |          |      |                              |  |   |  |  |        |  |  |  |   |  |  |
|---|--|---|--|-------------------|--|--|-------|--------|---|----------|------|------------------------------|--|---|--|--|--------|--|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   | FIRST  | MIDDLE            | LAST   | 2d. DATE OF DEATH  | MONTH | DAY    | YEAR  | 2b. HOUR |      |                              |  |   |  |  |        |  |  |  |   |  |  |
|   |  |   | HELEN  | DURGIN            |  | 10   | 7     | 85     | 1035 P  |          |      |                              |  |   |  |  |        |  |  |  |   |  |  |
| 3. SEX  |  |   | 4. RACE  | 5. DATE OF BIRTH  | 6. AGE (IN YEARS LAST BIRTHDAY)  | IF UNDER 1 YEAR  |       |        | IF UNDER 24 HRS.  |          |      |                              |  |   |  |  |        |  |  |  |   |  |  |
| Female  |  |   | WHITE  | 6 24 1888         | 97   | MONTHS   | YEARS | MONTHS | YEARS   | HOURS    | MIN. |                              |  |   |  |  |        |  |  |  |   |  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)   |  |   | 7b. CITIZEN OF WHAT COUNTRY?   | 8                 | MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH   |       |        | Montgomery County   |          |      |                              |  |   |  |  |        |  |  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH   |  |   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(NAME OF FACILITY, GIVE STREET ADDRESS) |                   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |       |        | 12b. KIND OF BUSINESS OR<br>INDUSTRY                              |          |      |                              |  |   |  |  |        |  |  |  |   |  |  |
| SANDY SPRING  |  |   | FRIENDS NURSING Home   |                   |  | Caterer  |       |        |   |          |      |                              |  |   |  |  |        |  |  |  |   |  |  |
| 13a. STATE  |  |   | 13b. COUNTY  | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS?   | 13e. STREET ADDRESS / ZIP CODE   |       |        |   |          |      |                              |  |   |  |  |        |  |  |  |   |  |  |
| Md.   |  |   | NORT.  | SANDY SPRNG       | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 17401 Norwood Rd. 20860  |       |        |   |          |      |                              |  |   |  |  |        |  |  |  |   |  |  |
| 14. FATHER'S NAME   |  |   | MIDDLE   | LAST              | 15. MOTHER'S MARRIED NAME  | 16. ADDRESS  |       |        |   |          |      |                              |  |   |  |  |        |  |  |  |   |  |  |
| GEORGE  |  |   |  | GROGAN            | MARY   | 208 Montgomery Ave.  |       |        |   |          |      |                              |  |   |  |  |        |  |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, UNKNOWN)  |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)  |                   |  | 17. INFORMANT  |       |        | Mr. Ralph Durgin North Wales, Pa.                                 |          |      |                              |  |   |  |  |        |  |  |  |   |  |  |
| NO  |  |   | 009-07-8149  |                   |  |  |       |        |   |          |      |                              |  |   |  |  |        |  |  |  |   |  |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for 18, 1b, and 1c) <table border="0" style="width: 100%;"> <tr> <td colspan="2" style="font-weight: bold;">PART I. DEATH WAS CAUSED BY:</td> <td style="text-align: right; width: 10%;">APPROXIMATE INTERVAL<br/>BETWEEN ONSET AND DEATH</td> </tr> <tr> <td colspan="2" style="padding-left: 20px;">IMMEDIATE CAUSE (a) <u>C.V.A. - left hemiparesis</u></td> <td style="text-align: right;">5 days</td> </tr> <tr> <td colspan="2" style="padding-left: 20px;">DUE TO, OR AS A CONSEQUENCE OF<br/>(b) <u>ASCOV</u></td> <td></td> </tr> <tr> <td colspan="2" style="padding-left: 20px;">DUE TO, OR AS A CONSEQUENCE OF<br/>(c) _____</td> <td></td> </tr> </table> |  |   |  |                   |  |  |       |        |   |          |      | PART I. DEATH WAS CAUSED BY: |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH | IMMEDIATE CAUSE (a) <u>C.V.A. - left hemiparesis</u> |  | 5 days | DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>ASCOV</u> |  |  | DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |
| PART I. DEATH WAS CAUSED BY:  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |                   |  |  |       |        |   |          |      |                              |  |   |  |  |        |  |  |  |   |  |  |
| IMMEDIATE CAUSE (a) <u>C.V.A. - left hemiparesis</u>  |  | 5 days  |  |                   |  |  |       |        |   |          |      |                              |  |   |  |  |        |  |  |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>ASCOV</u>  |  |   |  |                   |  |  |       |        |   |          |      |                              |  |   |  |  |        |  |  |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |   |  |                   |  |  |       |        |   |          |      |                              |  |   |  |  |        |  |  |  |   |  |  |
| <b>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</b><br><u>HYPERTENSION X 10 years</u>   |  |   |  |                   |  |  |       |        |   |          |      |                              |  |   |  |  |        |  |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                   |  | 20a. AUTOPSY?  |       |        | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH? |          |      |                              |  |   |  |  |        |  |  |  |   |  |  |
| -   |  |   |  |                   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |       |        | YES <input type="checkbox"/> NO <input type="checkbox"/>          |          |      |                              |  |   |  |  |        |  |  |  |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |                   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |       |        |   |          |      |                              |  |   |  |  |        |  |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                             |                   |  | 21f. LOCATION<br>STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____  |       |        |   |          |      |                              |  |   |  |  |        |  |  |  |   |  |  |
| <b>22a. I certify that (I) (this hospital) attended the deceased from 10-6, 1979, to Oct. 7, 1985, that (I) (we) last<br/>saw the deceased alive on Oct. 4, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br/>above, (I) (we) did (did not) view the body after death.</b>  |  |   |  |                   |  |  |       |        |   |          |      |                              |  |   |  |  |        |  |  |  |   |  |  |
| 22b. SIGNATURE<br><u>John S. Ladell, M.D.</u><br><u>by Frederick Moonan, M.D.</u>   |  |   | DEGREE   |                   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |       |        | 22c. DATE SIGNED<br>10-7-85                                       |          |      |                              |  |   |  |  |        |  |  |  |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>FREDERICK MOONAN</u>  |  |   | 22e. ADDRESS   |                   |  |  |       |        |   |          |      |                              |  |   |  |  |        |  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  |   | 23b. DATE<br>10-8-85   |                   |  | 23c. NAME OF CEMETERY OR CREMATORIAL<br>STATION  |       |        | 23d. LOCATION<br>CITY OR TOWN _____ COUNTY _____ STATE _____      |          |      |                              |  |   |  |  |        |  |  |  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME  |  |   | ADDRESS  |                   |  | 25a. DATE REC'D. BY REGISTRAR  |       |        | 25b. REGISTRAR'S SIGNATURE<br><u>Julian Davidson Pendleton</u>    |          |      |                              |  |   |  |  |        |  |  |  |   |  |  |
| Anatomy Board   |  |   | Balto., Md.  |                   |  | OCT 16 1985  |       |        |   |          |      |                              |  |   |  |  |        |  |  |  |   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please attach this certificate to the burial/transit permit. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be retained for use at the burial/transport permit. Then please remove certificate from Pages 1 and 2 should be filed within 72 hours of the death.

IMPORTANT: If item 23 is marked on Item 18, sign any injury, or other traumatic event, in medical examination box on page 3.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |  |  |  |  |  |   | 85 29012   |  |  |  |                 |  |
|--|--|--|---|--|--|--|--|--|---|--|--|--|--|-----------------|--|
|  |  |  |   |  |  |  |  |  |   | REG. NO.   |  |  |  |                 |  |
| 1- STATE REGISTRAR   |  |  | DECEASED NAME<br>(TYPE OR PRINT)  |  |  | FIRST MIDDLE LAST  |  |  | 2a DATE OF DEATH MONTH DAY YEAR   |  |  | 2b HOUR  |  |                 |  |
|  |  |  | EDWARD J. EARLE   |  |  |  |  |  | 10 14 85  |  |  | 9:30 A.M.  |  |                 |  |
| 3. SEX   |  |  | 4 RACE  |  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS |  |
| MALE   |  |  | White   |  |  | 2 15-1912  |  |  | 73  |  |  | MONTHS DAYS  |  | HOURS MIN.      |  |
| 7a BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)  |  |  | 7b CITIZEN OF WHAT COUNTRY?   |  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9 BALTIMORE CITY OR COUNTY OF DEATH   |  |  | MD.  |  |                 |  |
| WASH. D.C.   |  |  | U.S.A.  |  |  |  |  |  | MONTGOMERY CO.  |  |  |  |  |                 |  |
| 10 CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  | 12b KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |                 |  |
| TAKOMA PARK  |  |  | WASHINGTON ADVENTIST HOSPT.   |  |  | BOOKKEEPER   |  |  | U.S. GOV'T.   |  |  |  |  |                 |  |
| 13a STATE<br>VA.   |  |  | 13b COUNTY<br>NONE  |  |  | 13c CITY OR TOWN<br>ALEXANDRIA   |  |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                |  |  | 13e STREET ADDRESS / ZIP CODE<br>4373 RALEIGH AVE. 22304 |  |                 |  |
| 14 FATHER'S NAME<br>EDWARD   |  |  | MIDDLE J. LAST EARLE  |  |  | 15. MOTHER'S MAIDEN NAME<br>UNKNOWN  |  |  |   |  |  |  |  |                 |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES   |  |  | 16b SOCIAL SECURITY NO.<br>WWII   |  |  | 17 INFORMANT<br>DORIS E. EARLE   |  |  | ADDRESS<br>(SAME AS ITEM #13)   |  |  |  |  |                 |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)   |  |  |   |  |  |  |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>1 NR  |  |  |  |                 |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) COPD   |  |  |   |  |  |  |  |  |   | 20 yrs   |  |  |  |                 |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |  |   |  |  |  |  |  |   |  |  |  |  |                 |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>AS COVD   |  |  |   |  |  |  |  |  |   |  |  |  |  |                 |  |
| 19a DATE OF OPERATION  |  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |  |  |   |  |  |  |  |                 |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |   |  |  |  |  |                 |  |
| 22a. I certify that (I) (his hospital) attended the deceased from 25 SEP 1985 to 14 OCT 1985, that (I) (we) last saw the deceased alive on 13 OCT 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, check (w).) |  |  |   |  |  |  |  |  |   |  |  |  |  |                 |  |
| 22b. SIGNATURE<br>J. KELMAN MD   |  |  |   |  |  |  |  |  |   | 22c. DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/><br>DATE SIGNED<br>10/15/85 |  |  |  |                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>J. KELMAN   |  |  | 22e. ADDRESS<br>6521 BELLRIDGE RD., HYATTSVILLE, MD.  |  |  |  |  |  |   |  |  |  |  |                 |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  |  | 23b. DATE<br>10-17-1985   |  |  | 23c. NAME OF CEMETERY OR CREMATORIAL<br>QUANTICO NAT'L CEM.  |  |  | 23d. LOCATION<br>CITY OR TOWN<br>QUANTICO, COUNTY<br>VIRGINIA STATE   |  |  |  |  |                 |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>W. W. CHAMBERS CO. INC.  |  |  | ADDRESS<br>SILVER SPRING, Md.   |  |  | 25a. DATE REC'D. FOR REGISTRATION<br>OCT 28 1985   |  |  |   |  |  |  |  |                 |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8529013

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |        |  |                                     |       |  |  |          |                            |
|--|--|--|--|--------|--|-------------------------------------|-------|--|--|----------|----------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  | FIRST  | MIDDLE | LAST   | 2a. DATE OF DEATH                   | MONTH | DAY  | YEAR                                   | 2b. HOUR |                            |
| Margaret MARGARET v.   |  |  |  |        | EATON  | Eaton                               |       |  | 10/10/85 4:00PM                        |          |                            |
| 3. SEX   |  | 4 RACE   | 5 DATE OF BIRTH  |        |  | 6 AGE (IN YEARS LAST BIRTHDAY)      |       |  | 7 IF UNDER 1 YEAR                      |          |                            |
| Female   |  | Caucasian  | October 23, 1919   |        |  | 65                                  |       |  | MONTH DAYS                             |          |                            |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |        |  | 9 BALTIMORE CITY OR COUNTY OF DEATH |       |  | 8 IF UNDER 24 HRS<br>MONTHS HOURS MIN. |          |                            |
| Kansas   |  | USA  |  |        |  | Montgomery County, MD.              |       |  |  |          |                            |
| 10 CITY OR TOWN OF DEATH   |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |        | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)               |                                     |       | 12b. KIND OF BUSINESS OR<br>INDUSTRY   |  |          |                            |
| Silver Spring  |  | Chevy Chase Retirement & Nursing Center  |  |        | Homemaker  |                                     |       | Home   |  |          |                            |
| 13a. STATE   |  | 13b. COUNTY  |  |        | 13c. CITY OR TOWN  |                                     |       | 13e. STREET ADDRESS / ZIP CODE   |  |          |                            |
| Maryland   |  | Prince George's  |  |        | Brandywine   |                                     |       | 14520 Brandywine Heights Road 20613  |  |          |                            |
| 14. FATHER'S NAME  |  | FIRST  | MIDDLE   | LAST   | 15. MOTHER'S MAIDEN NAME   |                                     |       | FIRST  | MIDDLE                                 | LAST     |                            |
| George H. Dearing  |  |  |  |        | Lula M. Pringle  |                                     |       |  |  |          |                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  |        | 17. INFORMANT  |                                     |       | ADDRESS  |  |          |                            |
| No   |  | N/A  |  |        | Judi Mori - Newberg, Maryland  |                                     |       | Rural Route 1, Box 141 B 20664   |  |          |                            |
| 18. CAUSE OF DEATH<br>(Enter only one cause per line for 18a, 18b, and 18c.)<br>PART 1. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a)  |  |  |  |        |  |                                     |       | APPROXIMATE INTERVAL<br>BEWEEN ONSET AND DEATH   |  |          |                            |
|  |  |  |  |        | Lung & brain Ca metastases   |                                     |       | months   |  |          |                            |
|  |  |  |  |        | (b) Colon, carcinoma   |                                     |       | 2 yrs  |  |          |                            |
|  |  |  |  |        | (c)  |                                     |       |  |  |          |                            |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a   |  |  |  |        |  |                                     |       |  |  |          |                            |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |        | 20a. AUTOPSY?  |                                     |       | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?  |  |          |                            |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 or PART 2) |                                     |       | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>               |  |          |                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                   |  |        | 21f. LOCATION<br>STREET  |                                     |       | CITY OR TOWN COUNTY STATE  |  |          |                            |
| 22a. I certify that (I) (the hospital) attended the deceased from Aug 85 to date, that (I) (we) last saw the deceased alive on 10/14/85 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. |  |  |  |        |  |                                     |       |  |  |          |                            |
| 22b. SIGNATURE   |  |  |  |        | DEGREE   |                                     |       | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |          | 22c. DATE SIGNED           |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  |        | ADDRESS  |                                     |       |  |  |          | 10/10/85                   |
| This 6. MARD, 6116 Rohrman, Bethesda 20817   |  |  |  |        |  |                                     |       |  |  |          |                            |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 23b. DATE  |  |        | 23c. NAME OF CEMETERY OR CREMATORIAL   |                                     |       | 23d. LOCATION<br>CITY OR TOWN  |  |          |                            |
| Burial   |  | October 15, 1985   |  |        | Maryland Veterans Cemetery, Cheltenham, Maryland                               |                                     |       | COUNTY STATE   |  |          |                            |
| 24 FUNERAL DIRECTOR<br>NAME  |  | Lee Funeral Home, Inc.   |  |        | ADDRESS  |                                     |       | 25a. DATE REC'D. BY REGISTRAR  |  |          | 25b. REGISTRAR'S SIGNATURE |
|  |  |  |  |        |  |                                     |       | OCT 15 1985  |  |          |                            |
| DHMH - 16 60M 7/B4<br>(VRA 15, 4)  |  | 6638 Old Alexander Ferry Road, Clinton, Maryland   |  |        |  |                                     |       |  |  |          |                            |

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TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be left within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

309014

1 - FOR  
STATE  
REGISTRAR.STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8529014

REG. NO.

|  |  |   |  |   |      |   |       |   |         |  |  |  |  |
|--|--|---|--|---|------|---|-------|---|---------|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   | FIRST  | MIDDLE  | LAST | 2a. DATE OF DEATH   | MONTH | DAY   | YEAR    | 2b. HOUR   |  |  |  |
| <i>Rebecca Griffith Edwards</i>  |  |   |  |   |      | 10  | 30    | 85  | 5:49A M |  |  |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Caucasian</b>   |  | 5. DATE OF BIRTH<br>MONTH 6 DAY 19 YEAR 02  |      | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>83</b> YRS  |       | IF UNDER 1 YEAR<br>MONTHS <b>83</b> DAYS                                |         | IF UNDER 24 HRS<br>HOURS <b>5</b> MIN. <b>49</b> |  |  |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County MD</b>                             |       |   |         |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Holy Cross Hospital</b> |  | 12a. USUAL OCCUPATION<br><b>Librarian</b>   |      | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>College</b>   |       |   |         |  |  |  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Montgomery</b>  |  | 13c. CITY OR TOWN<br><b>Kensington</b>  |      | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |       | 13e. STREET ADDRESS / ZIP CODE<br><b>10225 Kensington Parkway 20895</b> |         |  |  |  |  |
| 4. FATHER'S NAME<br>FIRST <b>Howard</b> MIDDLE <b>Griffith</b> LAST  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Lutie</b> MIDDLE <b>Brewer</b> LAST |   |      |   |       |   |         |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>Yes</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>WWII 214-20-9880</b>   |  | 17. INFORMANT (Sister)<br><b>Mabel G. Littlepage</b>  |      | ADDRESS<br><b>2343 S. Queen St. Arlington, VA</b>   |       |   |         |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Respiratory Failure</i>  |  |   |  |   |      | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><i>immediate</i>                             |       |   |         |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <i>Chronic Obstructive Pulmonary Disease</i>   |  |   |  |   |      | DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>long standing</i>                                      |       |   |         |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |  |   |      |   |       |   |         |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |      | 20a. AUTOPSY?   |       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?          |         |  |  |  |  |
| YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | -   |  |   |      | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                             |       | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>     |         |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |      |   |       |   |         |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET   |      | CITY OR TOWN  |       | COUNTY  |         | STATE  |  |  |  |
| 22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from <b>10/29/85</b> to <b>10/30/85</b> , that <b>6</b> (we) last saw the deceased alive on <b>10/29/85</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. <b>(we) did not view the body after death.</b> |  |   |  |   |      |   |       |   |         |  |  |  |  |
| 22b. SIGNATURE<br><i>Jan Paul Krafking</i>   |  | 22c. DEGREE<br><i>MD</i>  |  | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>             |      | 22e. DATE SIGNED<br><b>10-30-85</b>   |       |   |         |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Jan Paul Krafking</i>  |  | 22e. ADDRESS<br><b>2101 Med PK Dr Silver Spring 20902</b>   |  |   |      |   |       |   |         |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>November 1, 1985</b>  |  | 23c. NAME OF CEMETERY OR CREMATORIUM<br><b>Arlington National</b>   |      | 23d. LOCATION<br>CITY OR TOWN<br><b>Arlington</b>   |       | COUNTY  |         | STATE<br><b>Virginia</b>                         |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Robert A. Pumphrey Funeral Homes</b><br>ADDRESS <b>P.O. 7557 Wisconsin Ave., Bethesda, MD</b> DATE REC'D. BY REGISTRAR <b>NOV 01 1985</b> REGISTRAR'S SIGNATURE <i>Robert A. Pumphrey</i>  |  |   |  |   |      |   |       |   |         |  |  |  |  |

110203

110203

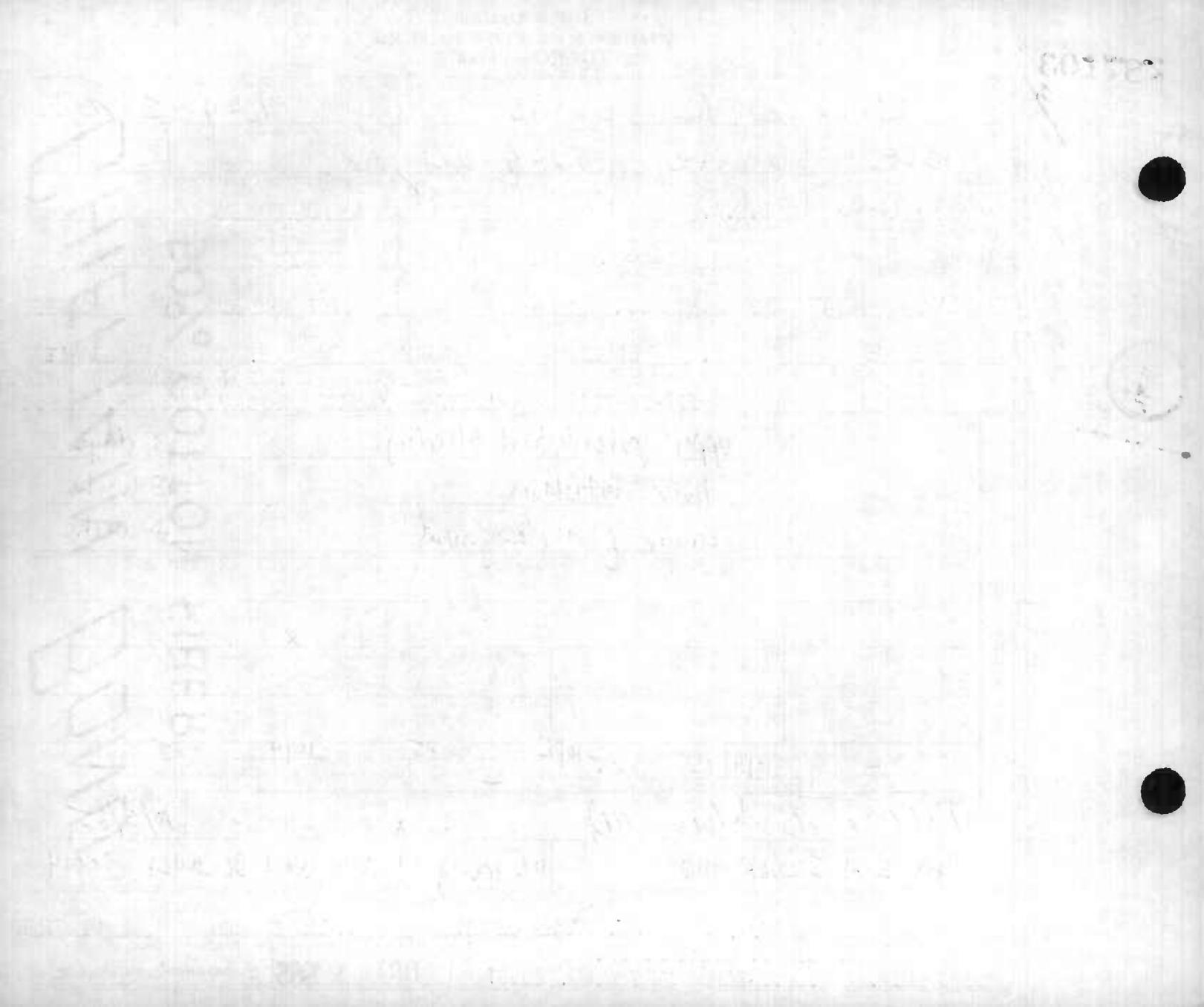
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be retained for use in the burial/transit permit. Then please remove carbon stamp. Item 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |                        |       |  |                                 |  |   | 8529015         |   |                |   |
|---|--|--|--|------------------------|-------|--|---------------------------------|--|---|-----------------|---|----------------|---|
| 1 - FOR STATE REGISTRAR   |  |  |  |                        |       |  |                                 |  |   | REG. NO.        |   |                |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  | FIRST  | MIDDLE                 | LAST  | 2d DATE OF DEATH   |                                 |  | MONTH   | DAY             | YEAR  | 2d HOUR        |   |
| George R.   |  |  |  | Elliis                 |       | 10-4-85  |                                 |  |   |                 |   | 00             |   |
| 3. SEX  |  |  | 4. RACE  | 5. DATE OF BIRTH       |       |  | 6. AGE (IN YEARS LAST BIRTHDAY) |  |   | IF UNDER 1 YEAR |   | 2d HOUR        |   |
| Male  |  |  | White  | Month 12 Day 9 Year 26 |       |  | 58                              |  |   | MONTHS          | DAYS  | 10P M          |   |
| 7a. BIRTHPLACE<br>(COUNTRY)   |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |                        |       | 8  |                                 |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                                 |                 |   | MD.            |   |
| Wash. D.C.  |  |  | U.S.A.   |                        |       | MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                 |  | MONTGOMERY  |                 |   |                |   |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                                  |                        |       | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |                                 |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |                 |   |                |   |
| Silver Spring   |  |  | Holy Cross Hospital  |                        |       | PRIEST   |                                 |  | CLERGY  |                 |   |                |   |
| 13a. STATE  |  |  | 13b. COUNTY  |                        |       | 13d. INSIDE CITY LIMITS?   |                                 |  | 13e. STREET ADDRESS / ZIP CODE                                      |                 |   |                |   |
| MARYLAND  |  |  | MONTGOMERY   |                        |       | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                 |  | 4101 NORBECK ROAD   |                 |   | 20853          |   |
| 14. FATHER'S NAME   |  |  | FIRST  | MIDDLE                 | LAST  | 15. MOTHER'S MAIDEN NAME   |                                 |  | FIRST   | MIDDLE          | LAST  |                |   |
| GEORGE  |  |  | R.   |                        | ELLIS | MARY   |                                 |  | E.  |                 |   | McCAULEY       |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |  | 16b. SOCIAL SECURITY NO.   |                        |       | 17. INFORMANT  |                                 |  | ADDRESS   |                 |   |                |   |
| NO  |  |  | 578-54-7248  |                        |       | FRIEND ALBERTA SUGGS   |                                 |  | 14301 BARKWOOD DRIVE<br>ROCKVILLE, MD. 20853                        |                 |   |                |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) upper gastrointestinal bleeding   |  |  |  |                        |       |  |                                 |  |   |                 |   |                | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>3 days |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) liver metastasis  |  |  |  |                        |       |  |                                 |  |   |                 |   |                | 8 wks   |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) cancer of rectosigmoid  |  |  |  |                        |       |  |                                 |  |   |                 |   |                | 8 weeks   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |                        |       |  |                                 |  |   |                 |   |                |   |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                        |       |  |                                 |  | 20a. AUTOPSY?   |                 | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH? |                |   |
|   |  |  |  |                        |       |  |                                 |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                 | YES <input type="checkbox"/> NO <input type="checkbox"/>          |                |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |                        |       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)   |                                 |  |   |                 |   |                |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |                        |       | 21f. LOCATION<br>STREET  |                                 |  | CITY OR TOWN  | COUNTY          | STATE   |                |   |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/4/85 to 10/12/85, 1985, to 10/14/85, 1985, that (I) (we) last saw the deceased alive on 10/4/85, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |                        |       |  |                                 |  |   |                 |   |                |   |
| 22b. SIGNATURE<br>Bruce A. Silver, MD   |  |  | DEGREE   |                        |       |  |                                 |  | 22c. DATE SIGNED<br>10/5/85   |                 |   |                |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>BRUCE A. SILVER, MD  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                        |       |  |                                 |  |   |                 |   |                |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  |  | 23b. DATE<br>BURIAL 10/9/85  |                        |       | 23c. NAME OF CEMETERY OR CREMATORIAL<br>ST. JAMES CEMETERY   |                                 |  | 23d. LOCATION<br>CITY OR TOWN FALLS CHURCH                          |                 |   | STATE VIRGINIA |   |
| 24. FUNERAL DIRECTOR<br>NAME FRANCIS J. COLLINS, JR.<br>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901   |  |  |  |                        |       | 25a. DATE REC'D. BY REGISTRAR OCT 9 1985   |                                 |  | 25b. REGISTRAR'S SIGNATURE<br>Julie Davidson Pendell                |                 |   |                |   |



291026

**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

29016

REF. NO.

|  |                         |   |   |   |  |
|--|-------------------------|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Charles Zachariah Evans</b>  |                         |   |   |   |  |
| FIRST  |                         | MIDDLE  | LAST  |   |  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 29 20 60</b>   | 6. AGE (IN YEARS<br>LAST BIRTHDAY)<br>YRS.<br><b>60</b>           | IF UNDER 1 YR.<br>MONTHS<br><b>0</b>  | IF UNDER 24 HRS.<br>DAYS HOURS MIN<br><b>0 0 0 0</b>       |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)<br><b>West Virginia</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED<br>WIDOWED<br><input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>         |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b>  |                         | 10. CITY OR TOWN OF DEATH<br><b>Rockville</b>   |   | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Residence 6 Lawrence Court</b> |  |
| 12a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><b>Maryland</b>   |                         | 13a. STATE<br><b>Maryland</b>   |   | 13b. COUNTY<br><b>Montgomery</b>  |  |
| 13c. CITY OR TOWN<br><b>Rockville</b>  |                         | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>6 Lawrence Court 20850</b>  |  |
| 14. FATHER'S NAME<br>FIR. <b>Harry</b>   |                         | MIDDLE<br><b>O.</b>   | LAST<br><b>Evans</b>  | 15. MOTHER'S MAIDEN NAME<br>MIDDLE<br><b>Ethel</b>  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>Yes</b>  |                         | 16b. SOCIAL SECURITY NO.<br><b>234-14-1457</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Patricia A. Evans 12732 Viers Mill Rd.</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>C cardio Respiratory Arrest</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause first.<br>(b) <b>Coronary anterioxclerosis</b><br>Due to, or as a consequence of<br>(c)  |                         |   |   |   |  |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |                         |   |   |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><b>Chronic obstructive pulmonary disease</b>  |                         |   |   |   |  |
| 19a. DATE OF OPERATION   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |   |  |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                         |   |   |   |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |                         | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)                                  |   | 21f. LOCATION<br>STREET<br>CITY OR TOWN<br>COUNTY<br>STATE  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |                         |   |   |   |  |
| ACTUAL SIGNATURE<br><b>John Gander</b>   |                         | TITLE (SPECIFY)<br>M.D. <b>Dept</b>   |   | DATE SIGNED<br><b>10-4-85</b>   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>John Gander</b>   |                         | MEDICAL EXAMINER<br><b>Bethesda Md.</b>   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |                         | 23b. DATE<br><b>10/12/85</b>  | 23c. NAME OF CEMETERY OR CREMATORIAL<br><b>Rockville Cemetery</b> |   | 23d. LOCATION<br>CITY OR TOWN<br><b>Rockville Maryland</b> |
| 24. FUNERAL DIRECTOR<br><b>Tyson Wheeler Funeral Home, Inc.</b>  |                         | ADDRESS<br><b>1331 Rockville Pike, Rockville, Maryland 20852</b>                                |   | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 16 1985</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>J. K. J.</b>  |                         |   |   |   |  |

200105

the second suite

three other suites

offices

are open

office space

Carry on

new business

etc.

etc.

etc.

business

etc. etc. etc.

etc. etc. etc.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon from pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

**304069**

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 29017

REG. NO.

|   |  |   |   |   |                          |  |                       |  |                       |                 |  |  |
|---|--|---|---|---|--------------------------|--|-----------------------|--|-----------------------|-----------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   | FIRST   | MIDDLE  | LAST                     | 2a. DATE OF DEATH  | MONTH                 | DAY  | YEAR                  | 2b. HOUR        |  |  |
| <b>Hosmer</b>   |  |   | <b>DOUGLAS FARR</b>                                     |   |                          | <b>10 23 85</b>  |                       |  |                       | <b>7:00 PM</b>  |  |  |
| 3. SEX  |  | 4. RACE   |   | 5. DATE OF BIRTH  |                          | 6. AGE (IN YEARS LAST BIRTHDAY)  |                       | IF UNDER 1 YEAR  |                       | IF UNDER 24 HRS |  |  |
| <b>MALE</b>   |  | <b>CAUCASIAN</b>  |   | <b>JUNE 17, 1947</b>  |                          | <b>38</b>  |                       |  |                       |                 |  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                          | 9. BALTIMORE CITY OR COUNTY OF DEATH   |                       | MD.  |                       |                 |  |  |
| <b>ALABAMA</b>  |  | <b>U.S.A.</b>   |   |   |                          | <b>MONTGOMERY</b>  |                       |  |                       |                 |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |   |                          | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |                       | 12b. KIND OF BUSINESS OR INDUSTRY                              |                       |                 |  |  |
| <b>SILVER SPRING</b>  |  | <b>HOLY CROSS HOSPITAL</b>  |   |   |                          | <b>MAIL CLERK</b>  |                       | <b>FEDERAL GOVT</b>  |                       |                 |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |   |   |                          |  |                       |  |                       |                 |  |  |
| 13a. STATE  |  | 13b. COUNTY   |   | 13c. CITY OR TOWN   |                          | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                    |                       | 13e. STREET ADDRESS / ZIP CODE                                 |                       |                 |  |  |
| <b>MARYLAND</b>   |  | <b>MONTGOMERY</b>   |   | <b>KENSINGTON</b>   |                          |  |                       | <b>10210 DRUMM AVENUE 20895</b>                                |                       |                 |  |  |
| 14. FATHER'S NAME   |  | FIRST<br><b>HOSMER</b>  | MIDDLE<br><b>L.</b>                                     | LAST<br><b>FARR, JR.</b>  | 15. MOTHER'S MAIDEN NAME |  | FIRST<br><b>JULIA</b> | MIDDLE<br><b>C.</b>  | LAST<br><b>COLLEY</b> |                 |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(IF NO OR UNKNOWN)  |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES) |   |                          | 17. INFORMANT  |                       |  | FATHER                |                 |  |  |
| <b>NO</b>   |  |   | <b>214-48-9067</b>                                      |   |                          | <b>HOSMER L. FARR, JR.</b>   |                       |  | <b>SAME AS 13</b>     |                 |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c))<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>pneumonia</b>  |  |   |   |   |                          | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH  |                       |  |                       |                 |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last   |  |   |   |   |                          |  |                       |  |                       |                 |  |  |
| (b) <b>Aspirin and compression</b>  |  |   |   |   |                          |  |                       |  |                       |                 |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Chemical renal failure</b>   |  |   |   |   |                          |  |                       |  |                       |                 |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a  |  |   |   |   |                          |  |                       |  |                       |                 |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   |                          | 20a. AUTOPSY?  |                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                       |                 |  |  |
|   |  |   |   |   |                          | YES <input type="checkbox"/> NO <input type="checkbox"/>   |                       | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                       |                 |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |                          |  |                       |  |                       |                 |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |   | 21f. LOCATION<br>STREET   |                          | CITY OR TOWN   |                       | COUNTY   |                       | STATE           |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Oct 23 1985</b> , to <b>Oct 23 1985</b> , that (I) (we) last saw the deceased alive on <b>Oct 23 1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. |  |   |   |   |                          |  |                       |  |                       |                 |  |  |
| 22b. SIGNATURE<br><b>Mark S. Rosen</b>  |  | DEGREE<br><b>MD</b>   |   |   |                          | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                       | 22c. DATE SIGNED<br><b>10/24/85</b>                            |                       |                 |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Mark S. Rosen, MD</b>   |  | 22e. ADDRESS<br><b>Silver Spring, MD</b>  |   |   |                          |  |                       |  |                       |                 |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE OR PRINT)  |  | 23b. DATE<br><b>10/26/85</b>  |   | 23c. NAME OF CEMETERY OR CREMATORIAL<br><b>JEFFERSON MEMORIAL</b>   |                          | 23d. LOCATION<br>CITY OR TOWN<br><b>TRUSSVILLE JEFFERSON AL</b>  |                       |  |                       |                 |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>FRANCIS J. COLLINS, JR.</b>  |  | ADDRESS<br><b>500 UNIV. BLVD., W., SILVER SPRING, MD.</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br>25b. REGISTRAR'S SIGNATURE<br><b>OCT 29 1985 John Davidson-Popell</b>  |                          |  |                       |  |                       |                 |  |  |

BP \_\_\_\_\_

DHMH - 16 60M 7/B4  
(VRA 15, 4)

630408



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician it should be detached for use as the burial/trust permit. Then please remove seal from paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |  |   |  |  | 85   | 29018 |                               |   |  |
|---|--|--|--|--|--|---|--|--|---|--|--|--|-------|-------------------------------|---|--|
|   |  |  |  |  |  |   |  |  |   |  |  | REG. NO.   |       |                               |   |  |
| 1. FOR<br>STATE<br>REGISTRAR  |  |  | I. DECEASED NAME<br>(TYPE OR PRINT)  |  |  | LAST  |  |  | 2d. DATE OF DEATH<br>MONTH DAY YEAR   |  |  | 2b. HOUR P.<br>5:30 M  |       |                               |   |  |
|   |  |  | Camilla A. D. FARRAHL  |  |  |   |  |  | 10/17/85  |  |  |  |       |                               |   |  |
| 3. SEX<br>Female  |  |  | 4. RACE<br>white   |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Jan. 5 1892   |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>93 YRS.  |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS                               |       | IF UNDER 24 HRS<br>HOURS MIN. |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>N. Carolina  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.  |  |  |  |       |                               |   |  |
| 10. CITY OR TOWN OF DEATH<br>Gaithersburg   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Wilson Health Care Center |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |       |                               |   |  |
| 13a. STATE<br>Md.   |  |  | 13b. COUNTY<br>Montgomery  |  |  | 13c. CITY OR TOWN<br>Gaithersburg   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  | 13e. STREET ADDRESS / ZIP CODE<br>9408 Horizon Run Rd. 20879 |       |                               |   |  |
| 14. FATHER'S NAME<br>FIRST<br>Joseph  |  |  | MIDDLE<br>Newton   |  |  | LAST<br>Lybn  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST<br>Lydia  |  |  | MIDDLE<br>-  |       |                               | LAST<br>Mitchell  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>-   |  |  | 17. INFORMANT<br>Lydia Barchers   |  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br>Due to, or as a consequence of<br>(b) <i>Cardiac Failure</i><br>Due to, or as a consequence of<br>(c) <i>Antroventricular Heart Disease</i> |  |  | ADDRESS<br>9408 Horizon Run Rd.<br>Gaithersburg, Md. 20879   |       |                               | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><i>immediate</i> |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |       |                               |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |   |  |  |  |       |                               |   |  |
| 21d. INJURY OCCURRED<br>WHITE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  | 21f. LOCATION<br>STREET<br>CITY OR TOWN<br>COUNTY<br>STATE  |  |  |   |  |  |  |       |                               |   |  |
| 22a. I certify that (I) <input type="checkbox"/> (the hospital) attended the deceased from <i>Oct 1980</i> , to <i>date</i> , that (I) <input type="checkbox"/> (we) lost<br>saw the deceased alive on <i>10/15/85</i> and that in (my) <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) <input type="checkbox"/> (we) did <input type="checkbox"/> (did not) view the body after death. |  |  |  |  |  |   |  |  |   |  |  | 22c. DATE SIGNED<br>10/18/85                                 |       |                               |   |  |
| 22b. SIGNATURE<br><i>Thos. G. Ward</i>  |  |  | 22c. DEGREE<br>M.D.  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  |  |   |  |  |  |       |                               |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Thos. G. WARD, 6116 Robinwood, Bethesda 20817  |  |  | 22e. ADDRESS   |  |  | 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |  | 23b. DATE<br>10/22/85   |  |  | 23c. NAME OF CEMETERY OR CREMATORIAL<br>Rock Creek Cemetery  |       |                               | 23d. LOCATION<br>CITY OR TOWN<br>Washington, D. C.                  |  |
| 24. FUNERAL DIRECTOR<br>Pauline Sandison<br>Gartner Sandison F.H. Gaithersburg, Md. 20877   |  |  | 24b. ADDRESS<br>316 E. Diamond Ave.  |  |  | 24c. DATE<br>10/22/85   |  |  | 24d. REGISTRATION BY REGISTRAR'S SIGNATURE<br><i>Pauline Sandison</i>   |  |  |  |       |                               |   |  |



304207

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM-3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSFER FORM. PAGES 1 AND 2 SHOULD BE KEPT WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

85 29019

REG. NO.

1- STATE REGISTRAR

1. DECEASED NAME  
(TYPE OR PRINT)

FIRST Anne

MIDDLE E.

LAST

Feuchak

2a. DATE KNOWN  
OF ESTI-  
DEATH MATED

MONTH DAY YEAR

2b. HOUR  
12:00  
PM

3. SEX

4. RACE

5. DATE OF BIRTH  
MONTH DAY YEAR6. AGE (IN YEARS  
LAST BIRTHDAY)  
TRRS.

7. IF UNDER 1 YR.

8. IF UNDER 24 HRS.

MONTHS

DAYS

HOURS

MIN

10. BIRTHPLACE  
(STATE OR  
FOREIGN COUNTRY)

New York

11. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED  
WIDOWEDNEVER MARRIED  
X

DIVORCED

12. CITY OR TOWN OF DEATH

Sil. Sp.

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION  
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Holy Cross Hosp

13. STATE

MD

14. CITY OR TOWN

Washington

13a. INSIDE CITY LIMITS?

YES NO 

13b. STREET ADDRESS

4600 Conn. Ave. N.W.

14. FATHER'S NAME

Thomas

MIDDLE

F.

LAST

Stackpole

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO OR UNKNOWN)  NO(IF YES, GIVE WAR OR DATES)  ---

16b. SOCIAL SECURITY NO.

17. INFORMANT

058-20-1058

ADDRESS

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

DUE TO, OR AS A CONSEQUENCE OF

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

None

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES  NO 

21a. EXTERNAL CAUSE WAS

UNDERLYING  ORCONTRIBUTING  CAUSE OF DEATH21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE  NOT WHILE AT WORK  AT WORK 21e. PLACE OF INJURY (AT HOME,  
STREET, FACTORY, FARM, ETC.)21f. LOCATION  
STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that I took charge of the remains described above, held an

Autopsy  Inspection  Inquiry  and in my opiniondeath resulted from: Natural causes  Accident  Suicide  Homicide  Undetermined manner 

ACTUAL SIGNATURE

John S. Rogers

M.D. D.P.M.

MEDICAL EXAMINER

DATE SIGNED Oct 24 1985

23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)

Burial

23b. DATE

10/23/85

23c. NAME OF CEMETERY OR CREMATORI

Holy Cross Cemetery

23d. LOCATION  
CITY OR TOWN

Brooklyn

COUNTY

STATE

24. FUNERAL DIRECTOR

NAME Joseph Gawler's Sons, Inc.

ADDRESS 5130 Wisconsin Ave, NW, Washington, D.C. 20016

25a. DATE REC'D. BY REGISTRAR

Oct 24 1985

25b. REGISTRAR'S SIGNATURE

29 *Journal*

270

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this form certify to be executed within 24 hours after death. Page 4 may be

ATTENDED by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please return to the funeral director. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |  |  |   |  |  |  | REG. NO.   |  |   |         |                                   |  |  |
|---|--|--|---|--|--|---|--|--|--|--|--|---|---------|-----------------------------------|--|--|
| 1 - FOR<br>STATE<br>REGISTRAR   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |  |   |  |  |  | 2b. HOUR   |  |   |         |                                   |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  | FIRST MIDDLE LAST   |  |  | Oct. 16 1985  |  |  |  |  |  |   | 9:04 AM |                                   |  |  |
| James C. Filgate  |  |  |   |  |  |   |  |  |  |  |  |   |         |                                   |  |  |
| 3. SEX  |  |  | 4. RACE   |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR  |  |  | 6. AGE [IN YEARS LAST BIRTHDAY]  |  |  | IF UNDER 1 YEAR   |         | IF UNDER 24 HRS                   |  |  |
| Male  |  |  | White   |  |  | March 24, 1899  |  |  | 86   |  |  | MONTHS  |         | DAYS HOURS MIN.                   |  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)   |  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  | YRS   |         |                                   |  |  |
| Washington, D.C.  |  |  | U.S.A.  |  |  |   |  |  | MONTGOMERY   |  |  | MD.   |         |                                   |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY   |  |  |   |         |                                   |  |  |
| Silver Springs  |  |  | Althea Woodland Nursing Home  |  |  | Bur. of Printing  |  |  | U.S. Govt.   |  |  | 99999   |         |                                   |  |  |
| 13a. STATE<br>none  |  |  | 13b. COUNTY<br>none   |  |  | 13c. CITY OR TOWN<br>Wash., D.C.  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  | 13e. STREET ADDRESS / ZIP CODE<br>4550 Conn. Ave., N.W. |         |                                   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |  |  | James F. Filgate  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |  |  | Nellie Cassell   |  |  |   |         |                                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR OATES)   |  |  | 17. INFORMANT<br>Margaret F. Smith 28 Wheeler Rd. Simsbury, Conn  |  |  | ADDRESS  |  |  | APPROXIMATE INTERVAL<br>ONSET AND DEATH                 |         |                                   |  |  |
| no  |  |  | 577-60-7303   |  |  |   |  |  |  |  |  | 3 days  |         |                                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Congestive Heart Failure   |  |  |   |  |  |   |  |  |  |  |  |   |         |                                   |  |  |
| DO TO, OR AS A CONSEQUENCE OF<br>(b) Chronic Obstructive Pulmonary Disease  |  |  |   |  |  |   |  |  |  | years  |  |   |         |                                   |  |  |
| DO TO, OR AS A CONSEQUENCE OF<br>(c)  |  |  |   |  |  |   |  |  |  |  |  |   |         |                                   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |   |  |  |   |  |  |  |  |  |   |         |                                   |  |  |
| Pulmonary Tuberculosis  |  |  |   |  |  |   |  |  |  |  |  |   |         |                                   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?   |  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |   |         |                                   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |   |         |                                   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |   |         |                                   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Dec. 19 83</u> , to <u>Oct. 16, 1985</u> , that (I) (we) last<br>saw the deceased alive on <u>Sept. 27 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death. |  |  |   |  |  |   |  |  |  |  |  |   |         |                                   |  |  |
| 22b. SIGNATURE<br><u>Russell M. Tilley M.D.</u>   |  |  |   |  |  |   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |         | 22c. DATE SIGNED<br>Oct. 16, 1985 |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Russell M. Tilley M.D.   |  |  |   |  |  |   |  |  |  | 22e. ADDRESS<br>4701 Mass. Ave., N.W. / Wash. D.C.   |  |   |         |                                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  |  | 23b. DATE<br>Burial Oct. 19, 1985   |  |  | 23c. NAME OF CEMETERY OR CREMATORIAL<br>Mt. Olivet Cemetery   |  |  | 23d. LOCATION<br>CITY OR TOWN<br>Washington, D.C.  |  |  | COUNTY STATE  |         |                                   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <u>John F. DeVol</u><br>ADDRESS <u>DeVol Funeral Home 2222 Wisc. Ave. Wash. DC</u>   |  |  |   |  |  | 25a. DATE REC'D. BY REGISTRAR<br>Oct. 21, 1985  |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Sylvia L. Johnson</u>   |  |  |   |         |                                   |  |  |

sent

that option

A.3.U. P.D. decisions

and A.3.I. indicates that such controls would reduce the risk of

allowing and/or

protect

freight

of 10% in safety

or more. It is believed that material "C" is

such a significant threat to health

that it is recommended that the use of such

is encouraged.

11.00

T

12

12.00 12.00 12.00

A.3.U. P.D. decisions

and A.3.I. indicates that such controls would reduce the risk of

allowing and/or

Items 18-22a 1/3/86 mth F#611 STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

310051

29021

FOR  
1 - STATE  
REGISTRAR

REG. NO.

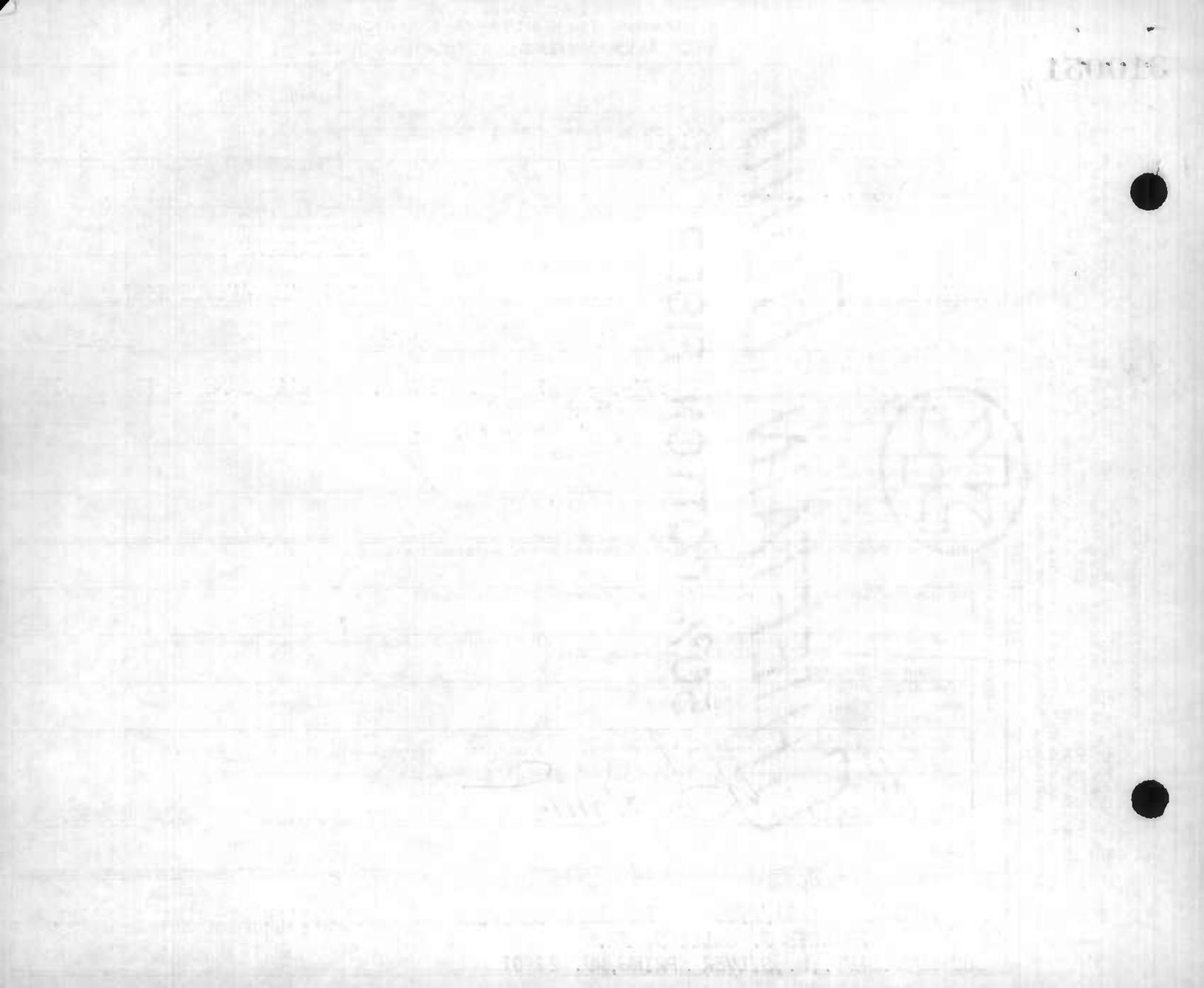
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

MEDICAL CERTIFICATION

|  |         |  |  |  |  |   |  |                        |                                      |              |               |                        |
|--|---------|--|--|--|--|---|--|------------------------|--------------------------------------|--------------|---------------|------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         |  |  | FIRST  | MIDDLE   | LAST  | 20. DATE KNOWN<br>OF ESTI-<br>DEATH MATED                      | X                      | MONTH                                | DAY          | YEAR          | 21b. HOUR              |
| Frank C. Finnell   |         |  |  |  |  |   | <input checked="" type="checkbox"/>                            |                        |                                      |              | 10/29/1985 85 |                        |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH<br>MONTH DAY YEAR   | 6. AGE (IN YEARS<br>LAST BIRTHDAY)<br>YRS. | IF UNDER 1 YR.   | IF UNDER 24 HRS.   | MONTHS DAYS HOURS MIN.  | 22c. DATE<br>PRONOUNCED<br>DEAD                                |                        | MONTH                                | DAY          | YEAR          | 23b. HOUR<br>8:40 P.M. |
| MALE   | WHITE   | MARCH 23, 1939   | 46   |  |  |   | 10/29/1985   |                        |                                      |              |               |                        |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |  |  | 8. MARRIED <input checked="" type="checkbox"/> EVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County, MD. |                        |                                      |              |               |                        |
| WASHINGTON, D.C.   |         | U.S.A.   |  |  |  |   |  |                        |                                      |              |               |                        |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)       |  |  |  |   | 12a. USUAL OCCUPATION<br>FOR MOST OF WORKING LIFE              |                        | 12b. KIND OF BUSINESS<br>OR INDUSTRY |              |               |                        |
| Silver Spring  |         | Holy Cross Hospital  |  |  |  |   | ELECTRICIAN  |                        |                                      |              |               |                        |
| 13a. STATE   |         | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS    |                                      |              |               |                        |
| MARYLAND   |         | MONTGOMERY   |  | SILVER SPRING  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                             |  | 9709 GLEN AVENUE 20910 |                                      |              |               |                        |
| 14. FATHER'S NAME<br>FIRST   |         | MIDDLE   |  | LAST   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST   |  | MIDDLE                 |                                      | LAST         |               |                        |
| FRANK  |         | C.   |  | FINNELL  |  | RUTH  |  |                        |                                      | BEALE        |               |                        |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |         | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | ADDRESS   |  |                        |                                      |              |               |                        |
| NO   |         | 578-50-9457  |  | SHARON L. FINNELL  |  | SAME AS 13  |  |                        |                                      | WIFE         |               |                        |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         |  |  |  |  |   |  |                        |                                      |              |               |                        |
| PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Amitriptyline intoxication  |         |  |  |  |  |   |  |                        |                                      |              |               |                        |
| DUE TO, OR AS A CONSEQUENCE OF   |         |  |  |  |  |   |  |                        |                                      |              |               |                        |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a) stating the under-<br>lying cause last.   |         |  |  |  |  |   |  |                        |                                      |              |               |                        |
| (b)  |         |  |  |  |  |   |  |                        |                                      |              |               |                        |
| DUE TO, OR AS A CONSEQUENCE OF   |         |  |  |  |  |   |  |                        |                                      |              |               |                        |
| (c)  |         |  |  |  |  |   |  |                        |                                      |              |               |                        |
| APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH  |         |  |  |  |  |   |  |                        |                                      |              |               |                        |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 20. AUTOPSY?   |  |   |  |                        |                                      |              |               |                        |
|  |         |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                    |  |   |  |                        |                                      |              |               |                        |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 10/29/1985   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>Subject ingested drug |  |   |  |                        |                                      |              |               |                        |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE<br>AT WORK <input checked="" type="checkbox"/> AT WORK  |         | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)<br>Home   |  | 21f. LOCATION<br>STREET<br>CITY OR TOWN<br>9709 Glen Rd. Silver Spring, Mont. Md.<br>COUNTY<br>STATE   |  |   |  |                        |                                      |              |               |                        |
| 22a. I certify that I took charge of the remains described above, held on<br>death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> |  | and in my opinion  |  |   |  |                        |                                      |              |               |                        |
| ACTUAL SIGNATURE<br><i>Dennis F. Smyth, M.D.</i>   |         | TITLE (SPECIFY)<br>M.D. Assistant  |  | MEDICAL EXAMINER   |  |   |  |                        |                                      |              |               |                        |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |         | ADDRESS  |  | DATE SIGNED 10/30/85   |  |   |  |                        |                                      |              |               |                        |
| Dennis F. Smyth, M.D.  |         | 111 Penn St.   |  |  |  |   |  |                        |                                      |              |               |                        |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |         | 23b. DATE<br>11/2/85   |  | 23c. NAME OF CEMETERY OR CREMATORIAL<br>PARKLAWN CEMETERY  |  | 23d. LOCATION<br>CITY OR TOWN<br>ROCKVILLE  |  | COUNTY<br>MONT         |                                      | STATE<br>MD. |               |                        |
| 24. FUNERAL DIRECTOR<br>NAME   |         | FRANCIS J. COLLINS, JR.  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 04 1985   |  | 25b. REGISTRAR'S SIGNATURE<br><i>John Randolph</i>  |  |                        |                                      |              |               |                        |
| 500 UNIV. BLVD. W., SILVER SPRING, MD. 20901   |         |  |  |  |  |   |  |                        |                                      |              |               |                        |

160016



DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANOTHER IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, AND 3 TO THE FUNERAL DIRECTOR.

**TO FUNERAL DIRECTOR:** PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES. PAGE 4 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

289145

1- STATE REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

85 29022

REG. NO.

|   |          |  |   |   |  |  |                                      |
|---|----------|--|---|---|--|--|--------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |          | FIRST<br><i>George</i>   | MIDDLE<br><i>Leslie</i>                                       | 2. DATE KNOWN TO<br>OF ESTI-<br>DEATH MATED   |  | MONTH DAY YEAR   | 479                                  |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH<br>MONTH DAY YEAR   | 6. AGE (IN YEARS<br>LAST BIRTHDAY)                            | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN  |  | 8. IF UNDER 24 HRS.                                    | 19 87 50 M                           |
| <i>m</i>  | <i>b</i> | <i>June 25 1928</i>  | <i>55 yrs.</i>  |   |  |  |                                      |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)  |          | 7b. CITIZEN OF WHAT COUNTRY?   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>             |  | 9. DATE PRONONCED<br>DEAD                              |                                      |
| <i>WASHINGTON, D.C.</i>   |          | <i>U.S.A.</i>  |   | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                |  | <i>Oct 9 1985</i>                                      |                                      |
| 10. CITY OR TOWN OF DEATH<br><i>8160 pg</i>   |          | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>10510 Bucknall Dr. Appt 103</i> |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY |
| 13a. STATE<br><i>Md</i>   |          | 13b. COUNTY<br><i>Montgomery</i>   | 13c. CITY OR TOWN<br><i>Wheaton</i>                           | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS<br><i>3818 DELANO STREET</i>       |                                      |
| 14. FATHER'S NAME<br>FIRST<br><i>GEORGE</i>   |          | MIDDLE<br><i>LLOYD</i>   | LAST<br><i>FISHER, JR.</i>                                    | 15. MOTHER'S MAIDEN NAME<br>FIRST<br><i>ANN</i>   |  | MIDDLE<br><i>ELIZABETH</i>                             | LAST<br><i>GRIFFIN</i>               |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)   |          | 16b. SOCIAL SECURITY NO.<br><i>410-04-6980</i>   |   | 17. INFORMANT<br><i>GEORGE L. FISHER, JR.</i>   |  | ADDRESS<br><i>SAME AS 13 FATHER</i>                    |                                      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |          |  |   |   |  |  |                                      |
| PART 1 DEATH WAS CAUSED BY:<br><br>IMMEDIATE CAUSE (a) <i>Hypoxia</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a) stating the under-<br>lying cause last.<br><br>(b) <i>Hanging</i><br>DUE TO, OR AS A CONSEQUENCE OF<br><br>(c)  |          |  |   |   |  |  |                                      |
| APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |          |  |   |   |  |  |                                      |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |          |  |   |   |  |  |                                      |
| None  |          | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>               |  |  |                                      |
| None  |          |  |   |   |  |  |                                      |
| 21a. DATE OF OPERATION<br><i>None</i>   |          | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>4:00 A.M. Sept 18 1985</i>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><i>Hung self</i> |  |  |                                      |
| 21d. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |          | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)<br><i>Home</i>  |   | 21f. LOCATION<br>STREET<br><i>Bucknall Dr. Silver Spring</i>                                      |  | CITY OR TOWN<br><i>Montgomery</i>                      | COUNTY<br><i>Md</i>                  |
| 21g. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK   |          |  |   |   |  | STATE<br><i>MD</i>                                     |                                      |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion<br>death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |          |  |   |   |  |  |                                      |
| ACTUAL<br>SIGNATURE<br><i>John S. Rogers</i>  |          | TITLE (SPECIFY)<br><i>M.D.</i>   |   | MEDICAL EXAMINER<br><i>Dep</i>  |  | DATE<br>SIGNED<br><i>Oct 9, 1985</i>                   |                                      |
| EXAMINER'S NAME<br>(TYPE OR PRINT)  |          | ADDRESS  |   | 1919 SEMINARY RD., SILVER SPRING, MD.   |  |  |                                      |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |          | 23b. DATE<br><i>BURIAL 10/11/85</i>  | 23c. NAME OF CEMETERY OR CREMATORIAL<br><i>GATE OF HEAVEN</i> | 23d. LOCATION<br>CITY OR TOWN<br><i>SILVER SPRING</i>   |  | COUNTY<br><i>MONT</i>                                  | STATE<br><i>MD.</i>                  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>FRANCIS J. COLLINS, JR.</i>  |          |  |   | 25a. DATE REC'D. BY REGISTRAR<br><i>OCT 14 1985</i>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Julian Taylor Jr.</i> |                                      |
| 500 UNTV. BLVD., W., SILVER SPRING, MD. 20901   |          |  |   |   |  |  |                                      |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

|   |  |   |        |  |            |   |                         |   |   |  |  |  |                             |
|---|--|---|--------|--|------------|---|-------------------------|---|---|--|--|--|-----------------------------|
| 1. DECEASED NAME  |  | William B   |        | MIDDLE   | Fitzgerald |   | 2a DATE OF DEATH        | MONTH   | DAY                                     | YEAR                                     | 2b HOUR  |  |                             |
| (TYPE OR PRINT)   |  |   |        |  | Fitzgerald |   | October 11, 1985        |   |   |  | 3:50 P.M.  |  |                             |
| 3. SEX  |  | Male  |        | RACE   | White      |   | S. DATE OF BIRTH        | MONTH   | DAY                                     | YEAR                                     |  |  |                             |
|   |  |   |        |  |            |   | Mar                     | 2   |   | 1901                                     |  |  |                             |
| 7a. BIRTHPLACE  |  | Virginia  |        | 7b. CITIZEN OF WHAT COUNTRY?   | USA        |   | 8                       | MARRIED <input checked="" type="checkbox"/>                     | NEVER MARRIED <input type="checkbox"/>  | WIDOWED <input type="checkbox"/>         | DIVORCED <input type="checkbox"/>                              | 6. AGE (IN YEARS LAST BIRTHDAY)                                      |                             |
| (STATE OR FOREIGN COUNTRY)  |  |   |        |  |            |   |                         | <input checked="" type="checkbox"/>                             | <input type="checkbox"/>                | <input type="checkbox"/>                 | <input type="checkbox"/>                                       | 84   |                             |
| 10 CITY OR TOWN OF DEATH  |  | Silver Spring   |        | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  |            |   |                         | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |   |  |  | 12b KIND OF BUSINESS OR INDUSTRY                                     |                             |
|   |  |   |        | Carriage Hill Nursing Home   |            |   |                         | Economist   |   |  |  | US Govt.   |                             |
| 13a STATE   |  | --  |        | 13b. CITY OR TOWN  |            | Washington, D.C.  |                         | 13d INSIDE CITY LIMITS?   |   | 13e STREET ADDRESS                       |  | MD.  |                             |
|   |  |   |        |  |            |   |                         | YES <input checked="" type="checkbox"/>                         | NO <input type="checkbox"/>             | 2500 Que St., N.W.                       |  |  |                             |
| 14 FATHER'S NAME  |  | FIRST   | MIDDLE | LAST   | Fitzgerald |   | 15 MOTHER'S MAIDEN NAME |   | 16 INFORMANT                            |  | ADDRESS  |  |                             |
|   |  | Alfred  | M.     |  |            |   | Lilia                   |   | Louise S. Fitzgerald-wife-(same as 13e) |  | Bradley  |  |                             |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES OR NO OR UNKNOWN)   |  | N/A   |        | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   |            | 112-07-0135   |                         | 17 INFORMANT  |   | ADDRESS                                  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                      |                             |
|   |  |   |        |  |            |   |                         |   |   |  |  | minutes  |                             |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:  |  | IMMEDIATE CAUSE (a) <u>Cardiopulmonary failure</u>                    |        |  |            |   |                         |   |   |  |  | DUE TO, OR AS A CONSEQUENCE OF                                       |                             |
|   |  |   |        |  |            |   |                         |   |   |  |  | (b) <u>Congestive heart failure</u>                                  | 1-2 hours                   |
|   |  |   |        |  |            |   |                         |   |   |  |  | (c) <u>Arteriosclerotic heart disease</u> <u>atrial fibrillation</u> | 20 years                    |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.                    |  |   |        |  |            |   |                         |   |   |  |  |  |                             |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                       |        |  |            |   |                         |   |   | 20a AUTOPSY?                             | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |                             |
|   |  |   |        |  |            |   |                         |   |   | YES <input type="checkbox"/>             | NO <input checked="" type="checkbox"/>                         | YES <input type="checkbox"/>   | NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY   |        | 21c HOW INJURY OCCURRED  |            | (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)    |                         |   |   |  |  |  |                             |
|   |  | HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                   |        |  |            |   |                         |   |   |  |  |  |                             |
| 21d. INJURY OCCURRED  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |        | 21f LOCATION   |            | CITY OR TOWN  |                         | COUNTY  |   | STATE                                    |  |  |                             |
|   |  |   |        | STREET   |            |   |                         |   |   |  |  |  |                             |
| 22a I certify that (I) (this hospital) attended the deceased from   |  |   |        | 1972   |            | to October 11, 1985                                     |                         |   |   |  |  |  |                             |
|   |  | say the deceased alive on <u>October 3 1985</u>                       |        | and that in (my) <u>last</u> opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |            |   |                         |   |   |  |  |  |                             |
| 22b. SIGNATURE  |  | William O. Bailey Jr. M.D.  |        | DEGREE   |            | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> |                         | MEDICAL DIRECTOR <input type="checkbox"/>                       |   | STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED   |                             |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)  |  | William O. Bailey Jr. M.D.  |        |  |            | 22e ADDRESS   |                         |   |   |  |  | 10/11/85   |                             |
|   |  |   |        |  |            | 2737 Devonshire Place, N.W., Wash, DC 20008             |                         |   |   |  |  |  |                             |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | Burial  |        | 23b DATE   |            | 23c NAME OF CEMETERY OR CREMATORIAL                     |                         | 23d LOCATION  |   | 23e COUNTY                               |  | 23f STATE  |                             |
|   |  |   |        | 10/17/85   |            | Fitzgerald Family Cemetery                              |                         | CITY OR TOWN  |   | Nelson                                   |  | Va.  |                             |
| 24 FUNERAL DIRECTOR   |  | Hines/Rinaldi Funeral Home  |        | ADDRESS  |            | 11800 N.H. Ave.,<br>S.S. Md. 20904                      |                         | 25a DATE REC'D. BY REGISTRAR                                    |   | 25b REGISTRAR'S SIGNATURE                |  |  |                             |
|   |  |   |        |  |            |   |                         | OCT 15 1985   |   |  |  |  |                             |

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician it should be detached for use at the burial-trust permit. Then please remove certain information from this certificate and attach it to the burial-trust permit. The medical examiner should be notified if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP  
DHMH 16 50A 1/81  
(VRA 15, 4)

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304188

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8529024

REG. NO.

1 - STATE  
REGISTRAR

|   |  |   |                |  |   |   |   |                                  |                  |                           |  |
|---|--|---|----------------|--|---|---|---|----------------------------------|------------------|---------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   | FIRST          | MIDDLE   | LAST  | 2a DATE OF DEATH  | MONTH   | DAY                              | YEAR             | 2b HOUR                   |  |
| <b>BETTY P FIVOZINSKY</b>   |  |   |                |  |   | <b>10-19-85</b>   |   |                                  |                  | <b>12<sup>55</sup> AM</b> |  |
| 3. SEX  |  | 4 RACE  |                | 5. DATE OF BIRTH   |   | 6 AGE (IN YEARS LAST BIRTHDAY)                                  |   | IF UNDER 1 YEAR                  |                  | IF UNDER 24 HRS           |  |
| <b>Female</b>   |  | <b>White</b>  |                | <b>Apr. 8, 1898</b>  |   | <b>87</b>   |   | MONTHS <b>YRS.</b>               |                  | MONTHS DAYS HOURS MIN.    |  |
| 7a BIRTHPLACE<br>COUNTRY  |  | 7b CITIZEN OF WHAT COUNTRY?   |                | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH                             |   | MD.                              |                  |                           |  |
| <b>Russia</b>   |  | <b>USA</b>  |                |  |   | <b>MONTGOMERY</b>   |   |                                  |                  |                           |  |
| 10 CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                |  |   | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |   | 12b KIND OF BUSINESS OR INDUSTRY |                  |                           |  |
| <b>Rockville</b>  |  | <b>Hebrew Home of Greater Wash. Housewife</b>   |                |  |   |   |   |                                  |                  |                           |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |                |  |   | 13d INSIDE CITY LIMITS?<br><b>YES X NO</b>                      |   | 13e STREET ADDRESS / ZIP CODE    |                  |                           |  |
| 13a STATE<br><b>Maryland</b>  |  | 13b COUNTY<br><b>Montgomery</b>   |                | 13c CITY OR TOWN<br><b>Rockville</b>   |   | <b>6111 Montrose Rd; 20852</b>                                  |   |                                  |                  |                           |  |
| 14 FATHER'S NAME<br>FIRST   |  | MIDDLE  | LAST           | 15. MOTHER'S MAIDEN NAME   |   |   |   |                                  |                  |                           |  |
| <b>Samuel</b>   |  |   | <b>Pivnick</b> | <b>Ida</b>   |   |   |   |                                  |                  |                           |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)  |                | 17. INFORMANT  |   | ADDRESS   |   | Md.                              |                  |                           |  |
| <b>No</b>   |  | <b>047-09-5609</b>  |                | <b>Irving Fivozinsky; 6111 Montrose Rd., Rockville</b>   |   |   |   |                                  |                  |                           |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a)   |  |   |                |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                 |   |                                  |                  |                           |  |
| <b>Cardio pulmonary arrest</b>  |  |   |                |  |   |   |   |                                  |                  |                           |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Acute CHF and pulmonary edema</b>  |  |   |                |  |   | 2-3 d   |   |                                  |                  |                           |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Upper respiratory Infection</b>  |  |   |                |  |   | 2-3 d   |   |                                  |                  |                           |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |                |  |   |   |   |                                  |                  |                           |  |
| CVA with aphasia, Prior MI with pulmonary edema   |  |   |                |  |   |   |   |                                  |                  |                           |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |                |  | 20a AUTOPSY?  |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?                                       |                                  |                  |                           |  |
|   |  |   |                |  | YES <input type="checkbox"/> NO <b>X</b>                              |   | YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                  |                  |                           |  |
| 21a ACCIDENT WAS UNDERLYING<br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR  |                |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 OR PART 2) |   |   |                                  |                  |                           |  |
|   |  | P.M. 19   |                |  |   |   |   |                                  |                  |                           |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                     |                |  | 21f LOCATION<br>STREET  |   | CITY OR TOWN  |                                  | COUNTY           | STATE                     |  |
|   |  |   |                |  |   |   |   |                                  |                  |                           |  |
| 22a. I certify that (1) <b>the hospital</b> attended the deceased from <b>9/11/1984</b> to <b>10/19/1985</b> , that (1) <b>we</b> saw the deceased alive on <b>10/19/1985</b> , and that in (my) <b>our</b> opinion death occurred on the date and hour and from the causes stated above. (1) <b>we</b> (did) <b>not</b> view the body after death. |  |   |                |  |   |   |   |                                  |                  |                           |  |
| 22b. SIGNATURE  |  | STANLEY CUTLER, MD  |                |  | DEGREE  |   | ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <b>X</b> |                                  | 22c. DATE SIGNED |                           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | <b>STANLEY CUTLER</b>   |                |  | 22e. ADDRESS  |   | <b>6121 MONTROSE ROAD<br/>ROCKVILLE, MARYLAND 20854</b>   |                                  | <b>10-19-85</b>  |                           |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE   |                | 23c. NAME OF CEMETERY OR CREMATORIAL   |   | 23d. LOCATION<br>CITY OR TOWN                                   |   | COUNTY                           |                  | STATE                     |  |
| <b>Burial</b>   |  | <b>10-20-1985</b>   |                | <b>King David Mem. Gdn.</b>  |   | <b>Falls Church, Virginia</b>                                   |   |                                  |                  |                           |  |
| 24. FUNERAL DIRECTOR<br>NAME  |  | ADDRESS   |                | 25a. DATE REC'D. BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE                                      |   |                                  |                  |                           |  |
| <b>Danzansky-Goldberg Mem. Chapels; 1170 Rockville Pike</b>   |  |   |                | <b>00723 1985</b>  |   | <b>gethardt@wmd.maryland.gov</b>                                |   |                                  |                  |                           |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove the top portion, pages 1 and 2, and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or interment.

IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

500128

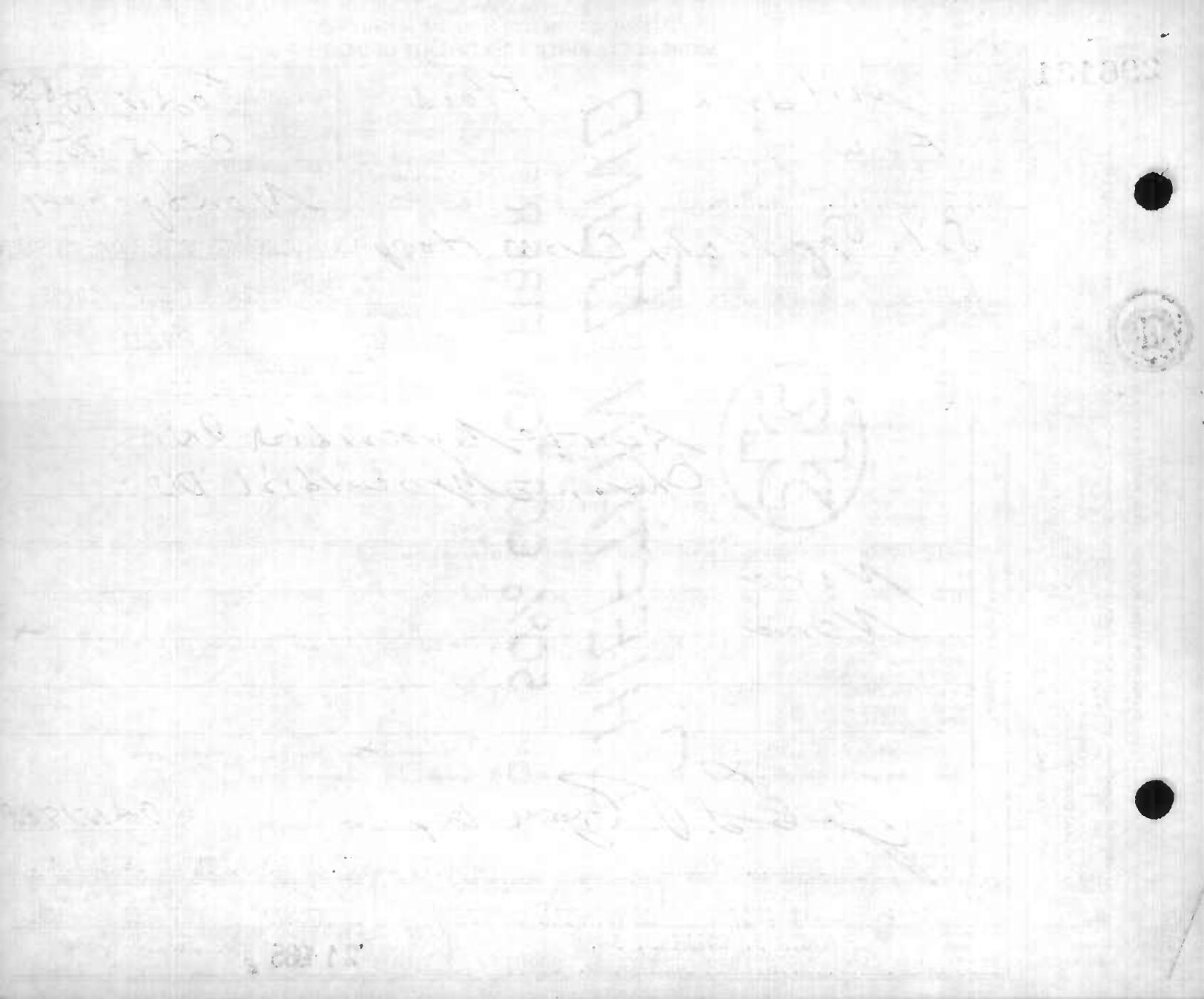
18 NOV 1969



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1-2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE RETAINED BY THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |                   |                                    |  |                |                  |  |      |       |                                      |                                |      | REG. NO. 85 29025                               |  |
|---|-------------------|------------------------------------|--|----------------|------------------|--|------|-------|--------------------------------------|--------------------------------|------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |                   |                                    | FIRST  | MIDDLE         | LAST             | 2a. DATE KNOWN<br>OF ESTI.<br>DEATH MATED  |      |       | MONTH                                | DAY                            | YEAR | 2b. MONTH                                       |  |
| <i>Mildred F. Flood</i>   |                   |                                    |  |                |                  | <i>Oct 12 1980</i>   |      |       | 10                                   | 12                             | 1980 | 10  |  |
| 3. SEX  | 4. RACE           | 5. DATE OF BIRTH<br>MONTH DAY YEAR | 6. AGE (IN YEARS<br>LAST BIRTHDAY)   | IF UNDER 1 YR. | IF UNDER 24 HRS. | MONTHS   | DAYS | HOURS | MIN                                  | 2c. DATE<br>PRONOUNCED<br>DEAD |      |   |  |
| <i>F</i>  | <i>w</i>          | <i>3 22 99</i>                     | <i>86 yrs.</i>   |                |                  |  |      |       |                                      | <i>Oct 15 1980</i>             |      |   |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)  |                   |                                    | 7b. CITIZEN OF WHAT COUNTRY?   |                |                  | 8. MARRIED<br><input type="checkbox"/> NEVER MARRIED<br><input checked="" type="checkbox"/> WIDOWED<br><input type="checkbox"/> DIVORCED |      |       | 9. BALTIMORE CITY OR COUNTY OF DEATH |                                |      |   |  |
| <i>WASHINGTON, D.C.</i>   |                   |                                    | <i>U.S.A.</i>  |                |                  |  |      |       | <i>Montgomery</i>                    |                                |      |   |  |
| 10. CITY OR TOWN OF DEATH   |                   |                                    | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                |                  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)   |      |       | 12b. KIND OF BUSINESS<br>OR INDUSTRY |                                |      |   |  |
| <i>27. Spa Royal Court Hotel</i>  |                   |                                    | <i>1024 LONG DISTANCE TELEPHONE OPERATOR</i>   |                |                  |  |      |       |                                      |                                |      |   |  |
| 13a. STATE  | 13b. COUNTY       | 13c. CITY OR TOWN                  | 13d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                       |                |                  | 13e. STREET ADDRESS  |      |       |                                      |                                |      |   |  |
| <i>MARYLAND</i>   | <i>MONTGOMERY</i> | <i>ROCKVILLE</i>                   |  |                |                  | <i>4520 ADRIAN STREET</i>  |      |       | <i>20853</i>                         |                                |      |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |                   |                                    | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST  |                |                  |  |      |       |                                      |                                |      |   |  |
| <i>CHARLES</i>  |                   |                                    | <i>ELIZABETH</i>   |                |                  |  |      |       | <i>MAHER</i>                         |                                |      |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><i>NO</i>  |                   |                                    | 16b. SOCIAL SECURITY NO.<br><i>578-50-0995</i>   |                |                  | 17. INFORMANT<br>GREAT NIECE<br><i>PATRICIA ROGERS</i>   |      |       | ADDRESS<br><i>SAME AS 13</i>         |                                |      |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Acute myocardial dis.</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <i>Chronic myocardial dis.</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |                   |                                    |  |                |                  |  |      |       |                                      |                                |      | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><i>None</i>  |                   |                                    |  |                |                  |  |      |       |                                      |                                |      |   |  |
| 19a. DATE OF OPERATION<br><i>None</i>   |                   |                                    | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |                |                  | 20. AUTOPSY?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |      |       |                                      |                                |      |   |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                   |                                    | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |                |                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)  |      |       |                                      |                                |      |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |                   |                                    | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)   |                |                  | 21f. LOCATION<br>STREET<br>CITY OR TOWN<br>COUNTY<br>STATE   |      |       |                                      |                                |      |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                   |                                    |  |                |                  |  |      |       |                                      |                                |      |   |  |
| 23a. EXAMINER'S NAME<br>(TYPE OR PRINT)<br><i>John S. Rogers</i>  |                   |                                    |  |                |                  |  |      |       |                                      |                                |      | TITLE (SPECIFY)<br><i>Medical Examiner</i>      |  |
| 23b. ADDRESS<br><i>1919 SEMINARY ROAD, SILVER SPRING, MD.</i>   |                   |                                    |  |                |                  |  |      |       |                                      |                                |      |   |  |
| 23c. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>BURIAL</i>   |                   |                                    | 23d. NAME OF CEMETERY OR CREMATORIAL<br><i>CEDAR HILL CEMETERY</i>   |                |                  | 23e. LOCATION<br>CITY OR TOWN<br><i>SUITLAND</i>   |      |       | COUNTY                               | STATE                          |      |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>FRANCIS J. COLLINS, JR.</i>  |                   |                                    | 25a. DATE REC'D. BY REGISTRAR<br><i>OCT 21 1985</i>  |                |                  | 25b. REGISTRAR'S SIGNATURE<br><i>John S. Rogers</i>  |      |       |                                      |                                |      |   |  |
| 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901   |                   |                                    |  |                |                  |  |      |       |                                      |                                |      |   |  |



298075

85 29026

**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|  |  |  |                                   |  |   |   |   |   |                   |          |              |
|--|--|--|-----------------------------------|--|---|---|---|---|-------------------|----------|--------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  | FIRST                             | MIDDLE                                       | LAST  | 2a. DATE OF DEATH   | MONTH   | DAY   | YEAR              | 2b. HOUR | 50 AM        |
| <i>Alsop</i>   |  |  | <i>Edward</i>                     | <i>Flowers, Jr.</i>                          |   | <i>October</i>  | <i>20</i>   | <i>85</i>   |                   | <i>9</i> | <i>50 AM</i> |
| 3. SEX   |  | 4. RACE  | 5. DATE OF BIRTH                  |  |   | 6. AGE (IN YEARS LAST BIRTHDAY)   |   |   | IF UNDER 1 YEAR   |          |              |
| <b>Male</b>  |  | <b>Caucasian</b>   | <b>MONTH October DAY 12, 1903</b> |  |   | <b>82 YRS</b>   |   |   | IF UNDER 24 HRS   |          |              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |                                   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   |   | 9. BALTIMORE CITY OR COUNTY OF DEATH                |                   |          |              |
| <b>Texas</b>   |  | <b>United States</b>   |                                   |  |   |   |   | <b>Montgomery County,</b>                           |                   |          |              |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                                  |                                   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |   |   | 12b. KIND OF BUSINESS OR INDUSTRY                   |                   |          |              |
| <b>Rockville</b>   |  | <b>Collingswood Nursing Home</b>   |                                   |  | <b>Manager</b>  |   |   | <b>Cement Plant</b>                                 |                   |          |              |
| 13a. STATE   |  | 13b. COUNTY  |                                   | 13c. CITY OR TOWN                            |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE                      |                   |          |              |
| <b>Texas</b>   |  | <b>Dallas</b>  |                                   | <b>Dallas</b>                                |   |   |   | <b>1224 Lausanne 99999 75208</b>                    |                   |          |              |
| 14. FATHER'S NAME  |  | FIRST  | MIDDLE                            | LAST   | 15. MOTHER'S MAIDEN NAME  |   |   | ADDRESS   |                   |          |              |
|  |  | <b>Alsop</b>   | <b>Edward</b>                     | <b>Flowers</b>                               | <b>Emma</b>   |   |   | <b>10 Hastings Circle Rockville, Maryland 20850</b> |                   |          |              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)  |                                   | 17. INFORMANT                                |   |   | 18. APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |   |                   |          |              |
| <b>No</b>  |  | <b>461-09-1964</b>   |                                   | <b>Karen R. Brustman</b>                     |   |   | <b>ACUTE</b>  |   |                   |          |              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>ASystole</i>  |  |  |                                   |  |   |   |   |   |                   |          |              |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>ASHD</i>  |  |  |                                   |  |   |   |   |   |                   |          |              |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause lost.<br>(c)   |  |  |                                   |  |   |   |   |   |                   |          |              |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |                                   |  |   |   |   |   |                   |          |              |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                   |  | 20a. AUTOPSY?   |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |                   |          |              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |                                   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |   |   |                   |          |              |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |                                   |  | 21f. LOCATION<br>STREET   |   | CITY OR TOWN  |   |                   | COUNTY   | STATE        |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>9/20</i> to <i>1985</i> , that (my) (we) (did) (did not) view the body after death, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. |  |  |                                   |  |   |   |   |   |                   |          |              |
| 22b. SIGNATURE <i>Thomas E. Doddy, MD</i>  |  |  |                                   |  |   |   |   |   |                   |          |              |
| 22c. DATE SIGNED <i>08/21/1985</i>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                   |  | 22d. ADDRESS <i>17904 GOORSON AVE</i>   |   |   |   |                   |          |              |
| 22e. ADDRESS <i>OLNEY, MD 20832</i>  |  |  |                                   |  |   |   |   |   |                   |          |              |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 23b. DATE  |                                   | 23c. NAME OF CEMETERY OR CREMATORIAL<br>HOME |   |   | 23d. LOCATION   |   | 23e. CITY OR TOWN |          | STATE        |
| Burial   |  | <i>Oct. 23, 1985</i>   |                                   | <i>Laurel Land Cemetery</i>                  |   |   | <i>Dallas</i>   |   | <i>Dallas</i>     |          | <i>Texas</i> |
| 24. FUNERAL DIRECTOR <i>Robert A. Pumphrey Funeral HomesPA</i><br>NAME <i>7557 Wisconsin Ave Bethesda, Maryland. 20814</i>   |  | 25a. DATE REC'D. BY REGISTRAR <i>Oct 23 1985</i>   |                                   |  | 25b. REGISTRAR'S SIGNATURE <i>Robert A. Pumphrey</i>  |   |   |   |                   |          |              |

250200



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate  
be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3  
should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death  
with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

296135

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 29027

REG. NO.

|   |  |  |                                |  |                          |   |                    |  |  |                                      |  |
|---|--|--|--------------------------------|--|--------------------------|---|--------------------|--|--|--------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  | FIRST                          | MIDDLE   | LAST                     | 2a DATE OF DEATH  | MONTH              | DAY  | YEAR   | 2b HOUR                              |  |
|   |  |  | <b>RAYMOND HENRY FLUBACHER</b> |  |                          | <b>OCTOBER 15 1985</b>  |                    |  | <b>10:05 P</b>                                       |                                      |  |
| 3. SEX  |  | 4 RACE   |                                | 5 DATE OF BIRTH  |                          | 6. AGE (IN YEARS LAST BIRTHDAY)   |                    | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS                      |  |
| MALE  |  | CAUCASIAN  |                                | MONTH DAY YEAR<br><b>JULY 28 1913</b>  |                          | 72 YRS  |                    | MONTHS DAYS  |  | HOURS MIN.                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |                                | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                          | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY County MD.</b>                            |                    |  |  |                                      |  |
| RHODE ISLAND  |  | UNITED STATES  |                                |  |                          |   |                    |  |  |                                      |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>NAVAL HOSPITAL</b> |                                |  |                          | 12a. USUAL OCCUPATION<br><b>Transportation Specialist</b>                                       |                    |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S.NAVY</b> |                                      |  |
| BETHESDA  |  |  |                                |  |                          |   |                    |  |  |                                      |  |
| 13a. STATE  |  | 13b. COUNTY  |                                | 13c. CITY OR TOWN  |                          | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                    | 13e. STREET ADDRESS / ZIP CODE<br><b>10 GUY Court 20850</b>  |  |                                      |  |
| MARYLAND  |  | MONTGOMERY   |                                | ROCKVILLE  |                          |   |                    |  |  |                                      |  |
| 14. FATHER'S NAME   |  | FIRST  | MIDDLE                         | LAST   | 15. MOTHER'S MAIDEN NAME |   | FIRST              | MIDDLE   | LAST   |                                      |  |
|   |  | <b>GEORGE FLUBACHER</b>  |                                |  |                          |   | <b>MARIE LABAT</b> |  |  |                                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)  |                                | 16c. INFORMANT   |                          | ADDRESS   |                    |  |  |                                      |  |
| YES   |  | 1939-1967  |                                | 083-05-1307  |                          | <b>YVETTE FLUBACHER, 10 GUY Court, ROCKVILLE, MD</b>  |                    |  |  |                                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause last<br>(b)<br>(c)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |                                |  |                          |   |                    |  |  |                                      |  |
| APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |  |                                |  |                          |   |                    |  |  |                                      |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |                                |  |                          |   |                    |  |  |                                      |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                |  |                          | 20a. AUTOPSY?   |                    | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                                      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |                                | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |                          |   |                    |  |  |                                      |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |                                | 21f. LOCATION<br>STREET  |                          | CITY OR TOWN  |                    | COUNTY   |  | STATE                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>OCTOBER 13 1985</b> , to <b>OCTOBER 15 1985</b> , that (I) (we) last<br>saw the deceased alive on <b>OCTOBER 15 1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.        |  |  |                                |  |                          |   |                    |  |  |                                      |  |
| 22b. SIGNATURE<br><i>B. L. Flax</i>   |  | DEGREE<br><i>ms</i>  |                                | ATTENDING PHYSICIAN <input type="checkbox"/>   |                          | MEDICAL DIRECTOR <input type="checkbox"/>   |                    | STAFF PHYSICIAN <input checked="" type="checkbox"/>  |  | 22c. DATE SIGNED<br><b>16 OCT 85</b> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>B. L. FLAX, LT, MC, USNR</b>  |  | 22e. ADDRESS<br><b>NAVAL HOSPITAL, NAVAL MEDICAL COMMAND,<br/>NATIONAL CAPITAL REGION, BETHESDA, MD 20814</b>                      |                                |  |                          |   |                    |  |  |                                      |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE Oct. 18, 1985  |                                | 23c. NAME OF CEMETERY OR CREMATORIAL<br><b>Cedar Hill Cemetery</b>   |                          | 23d. LOCATION<br>CITY OR TOWN<br><b>Suitland, Maryland</b>                                      |                    | 23e. COUNTY STATE  |  |                                      |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Robert A. Pumphrey Funeral Homes, P.A. Rockville, Maryland 20850</b>   |  |  |                                |  |                          | 25a. DATE REC'D. BY REGISTRAR<br><b>Oct 21 1985</b>   |                    | 25b. REGISTRAR'S SIGNATURE<br><i>BP</i>  |  |                                      |  |



University of Michigan  
Ann Arbor

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

310061

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be signed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and page 4, within 24 hours after death.

**HOSPITAL ATTENDING PHYSICIAN:** The law requires that

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that one death certificate be issued within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**0 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and my event.

|  |  |  |   |  |  |  |   |  |                       |
|--|--|--|---|--|--|--|---|--|-----------------------|
| 1. DECEASED NAME<br>(Type or print)  |  | First<br><b>Catherine</b>  | Middle<br><b>Clare</b>  | Last<br><b>Frei</b>  | 2a. DATE OF DEATH<br>Month Day Year<br><b>10/23/85</b>   | 2b. HOUR<br><b>10:30 AM</b>  |   |  |                       |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>CAUCASIAN</b>  |   | 5. DATE OF BIRTH<br><b>10/23/85</b>  |  | 6. AGE (In years last birthday)<br>YRS.<br><b>10</b>                 | IF UNDER 1 YEAR<br>MONTHS<br><b>0</b>                 | IF UNDER 24 HRS.<br>HOURS<br><b>0</b>        | MIN.<br><b>0</b>      |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED<br><input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH<br><b>Montgomery</b>  |  | Md.   |  |                       |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Holy Cross Hospital</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>N/A</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>99999 20009</b>              |   |  |                       |
| 13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE<br><b>Wash, DC</b>  |  | 13b. COUNTY<br><b>N/A</b>  | 13c. CITY OR TOWN<br><b>Wash, DC</b>                          | 13d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  | 13e. STREET AND NUMBER<br><b>2010 Kalorama Rd NW</b>   |  |   |  |                       |
| 14. FATHER'S NAME First<br><b>Thomas</b>   |  | Middle<br><b>A.</b>  | Last<br><b>Frei</b>   | 15. MOTHER'S MAIDEN NAME First<br><b>Tracey</b>  | Middle<br><b>Wold</b>  |  |   |  |                       |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>N/A</b>   |   | 17. INFORMANT<br><b>THOMAS A. FREI</b>   | Address<br><b>SAME AS 13 FATHER</b>  |  |   |  |                       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Asphyxia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Severe Pulmonary Compromise</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Achondroplasia genesis Syndrome</b> |  |  |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                       |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |   |  |  |  |   |  |                       |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |  | 20a. AUTOPSY?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |  |                       |
| 21a. ACCIDENT WAS UNDERLYING<br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |   |  |                       |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                            |   | 21f. LOCATION Street or R.F.D. No.   | City or Town   |  | County  | State  |                       |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |  |  |  |   |  |                       |
| 22b. SIGNATURE<br><b>Georgis G-kefale MD</b>   |  | DEGREE   | ATTENDING PHYS.   | <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  | 22c. DATE SIGNED<br><b>10/23/85</b>  |  |   |  |                       |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Georgis G-kefale</b>  |  | 22e. ADDRESS<br><b>Holy Cross Hospital, Silver Spring, Md.</b>   |   |  |  |  |   |  |                       |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>10/30/85</b>   | 23c. NAME OF CEMETERY OR CREMATORIAL<br><b>GATE OF HEAVEN</b> |  |  | 23d. LOCATION (City or Town)<br><b>SILVER SPRING</b>                 |   | (County)<br><b>MONT</b>                      | (State)<br><b>MD.</b> |
| 24. FUNERAL DIRECTOR <b>FRANCIS J. COLLINS JR.</b><br><b>500 UNIV. BLVD. W., SILVER SPRING, MD.</b>  |  |  |   |  | 25a. REC'D BY REGISTRAR<br><b>DATE 10/24/85</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Georgis G-kefale</b> |  |                       |

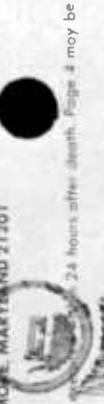
Georgian Gothic

Holy Cross Hospital, Silver Spring

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-trust permit. Then please remove carbon paper, page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



287107

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be returned by the hospital or attending physician.

85 29029

**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH**

REG. NO.

1 - STATE REGISTRAR

1a. DECEASED NAME (TYPE OR PRINT)

FIRST MIDDLE LAST

LAST

2a. DATE OF DEATH MONTH DAY YEAR

2b. HOUR

3. SEX

4. RACE

5. DATE OF BIRTH

6. AGE (IN YEARS LAST BIRTHDAY)

2b. HOUR

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

7b. CITIZEN OF WHAT COUNTRY?

MONTH

DAY

YEAR

IF UNDER 1 YEAR

IF UNDER 24 HRS

8. MARRIED  NEVER MARRIED 

9. BALTIMORE CITY OR COUNTY OF DEATH

MONTHS DAYS

HOURS MIN.

WIDOWED  DIVORCED 

52

YRS

10. CITY OR TOWN OF DEATH

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

12a. USUAL OCCUPATION

12b. KIND OF BUSINESS OR INDUSTRY

13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

14. FATHER'S NAME

MIDDLE

13d. INSIDE CITY LIMITS?

13e. STREET ADDRESS / ZIP CODE

15. MOTHER'S MAIDEN NAME

LAST

YES  NO 

14. FATHER'S NAME

FIRST

ADDRESS

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

16b. SOCIAL SECURITY NO.

17. INFORMANT

(YES, NO OR UNKNOWN)

(IF YES GIVE WAR OR DATES)

ADDRESS

NO

579-48-5417

JAMES R. FRYER

SAME AS 13

HUSBAND

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

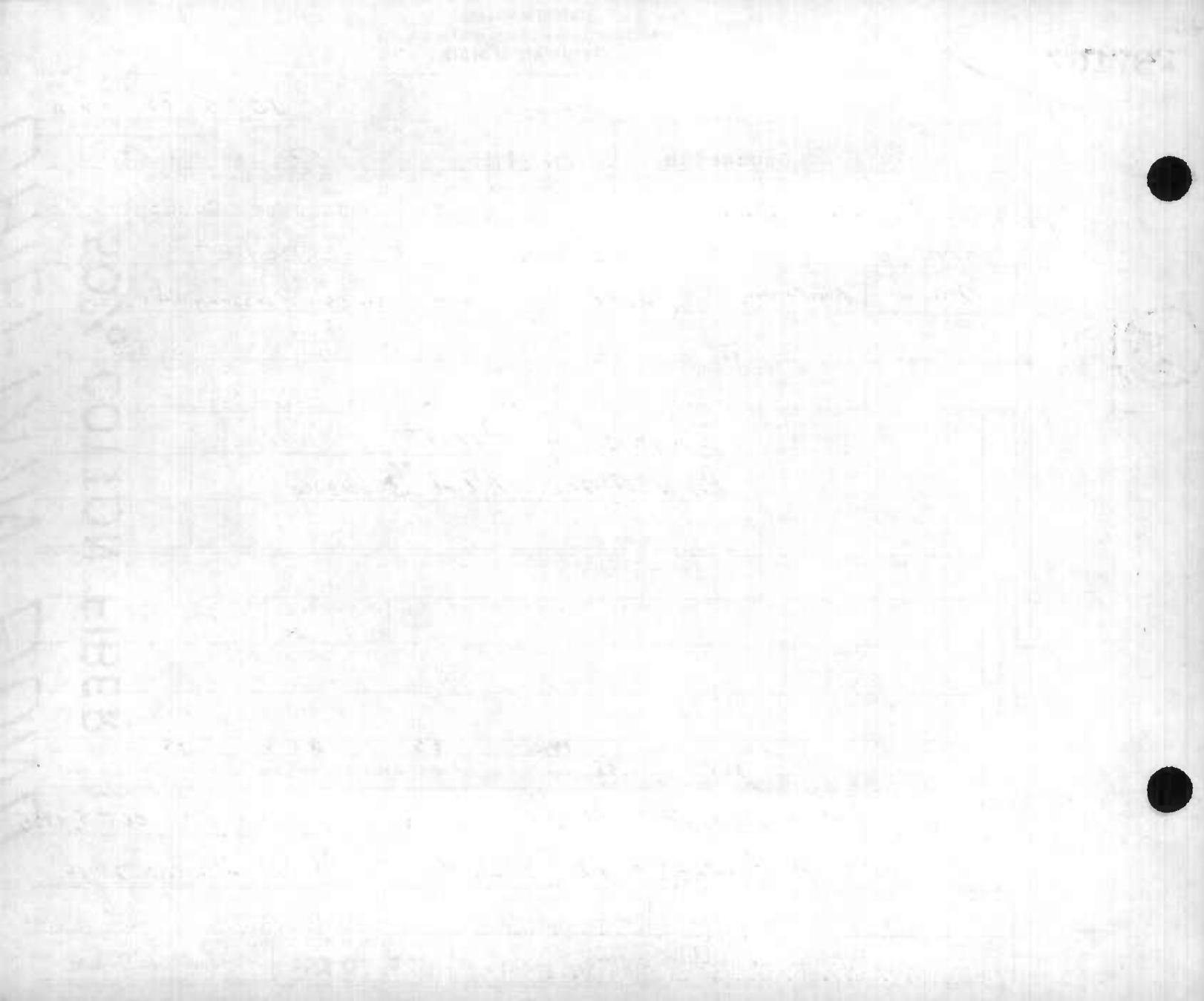
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)



310008

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8529030

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove certificates. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

|  |  |   |  |   |                          |   |       |   |                  |                  |  |
|--|--|---|--|---|--------------------------|---|-------|---|------------------|------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   | FIRST  | MIDDLE  | LAST                     | 20. DATE OF DEATH   | MONTH | DAY   | YEAR             | 26. HOUR         |  |
| KAROLINE   |  |   |  |   | Fuerchheimer             | 10  | -25   | -85   | 6:50 A           |                  |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH  |                          | 6. AGE (IN YEARS LAST BIRTHDAY)   |       | IF UNDER 1 YEAR   |                  | IF UNDER 24 HRS. |  |
| Female   |  | White   |  | MONTH DAY YEAR<br>June 26, 1895   |                          | 90  |       | MONTHS DAYS   |                  | HOURS MIN.       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                          | 9. BALTIMORE CITY OR COUNTY OF DEATH  |       |   |                  |                  |  |
| Germany  |  | U.S.A.  |  |   |                          | MONTGOMERY  |       | MD.   |                  |                  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |                          | 12b. KIND OF BUSINESS OR INDUSTRY   |       |   |                  |                  |  |
| Bethesda   |  | Suburban  |  | Homemaker   |                          |   |       |   |                  |                  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   |                          | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |       |   |                  |                  |  |
| 13a. STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |                          | 13e. STREET ADDRESS / ZIP CODE<br>9414 Linden Avenue (20814)                                    |       |   |                  |                  |  |
| Maryland   |  | Montgomery  |  | Bethesda  |                          |   |       |   |                  |                  |  |
| 14. FATHER'S NAME  |  | FIRST   | MIDDLE   | LAST  | 15. MOTHER'S MAIDEN NAME |   | FIRST | MIDDLE  | LAST             |                  |  |
|  |  | Otmar   |  | Strauss   | Katharina                |   |       |   | Isaac            |                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>214-52-2739 |   |                          | 17. INFORMANT<br>Ronald Hauptman; 6106 32nd St., N.W.; Wash., D.C.                              |       |   | ADDRESS<br>20015 |                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>(IMMEDIATE CAUSE (a))   |  |   |  |   |                          | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>5 DAYS                                       |       |   |                  |                  |  |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause last.  |  |   |  |   |                          | DO TO, OR AS A CONSEQUENCE OF<br>(b) congestive Heart Failure<br>5 years                        |       |   |                  |                  |  |
| { DO TO, OR AS A CONSEQUENCE OF<br>(c) arteriosclerotic Heart Disease<br>20 years  |  |   |  |   |                          |   |       |   |                  |                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a<br>chronic obstructive Lung Disease   |  |   |  |   |                          |   |       |   |                  |                  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |                          | 20a. AUTOPSY?   |       | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH? |                  |                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                          | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                             |       | YES <input type="checkbox"/> NO <input type="checkbox"/>          |                  |                  |  |
| 21d. INJURY OCCURRED<br>WHITE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/><br>AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET   |                          | CITY OR TOWN  |       | COUNTY  |                  | STATE            |  |
| 22a. I certify that (I) (his hospital) attended the deceased from 19 74 to 10-25 19 85, that (I) (we) last saw the deceased alive on 10-24 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |                          |   |       |   |                  |                  |  |
| 22b. SIGNATURE<br>Herbert L. Tanenbaum   |  | 22c. DEGREE<br>Am   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |                          | 22d. DATE SIGNED<br>10/25/80  |       |   |                  |                  |  |
| 22e. PHYSICIAN'S NAME, TYPE OR PRINT<br>Herbert L. Tanenbaum   |  | 22f. ADDRESS<br>5480 Wisconsin Ave Chevy Chase, Md 20815  |  |   |                          |   |       |   |                  |                  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>SPECIFY<br>Burial   |  | 23b. DATE<br>10/27/85   |  | 23c. NAME OF CEMETERY OR CREMATORIAL<br>King David Mem. Garden Falls Church; Fairfax; Virginia  |                          | 23d. LOCATION<br>CITY OR TOWN   |       | COUNTY  |                  | STATE            |  |
| 24. FUNERAL DIRECTOR<br>NAME DANZANSKY-GOLDBERG MEMORIAL CHAPEL<br>1170 Rockville Pike; Rockville, Md. 20852   |  | 25a. DATE RECEIVED BY REGISTRAR<br>10-29-85   |  | 25b. REGISTRAR'S SIGNATURE<br>John Danzansky  |                          |   |       |   |                  |                  |  |



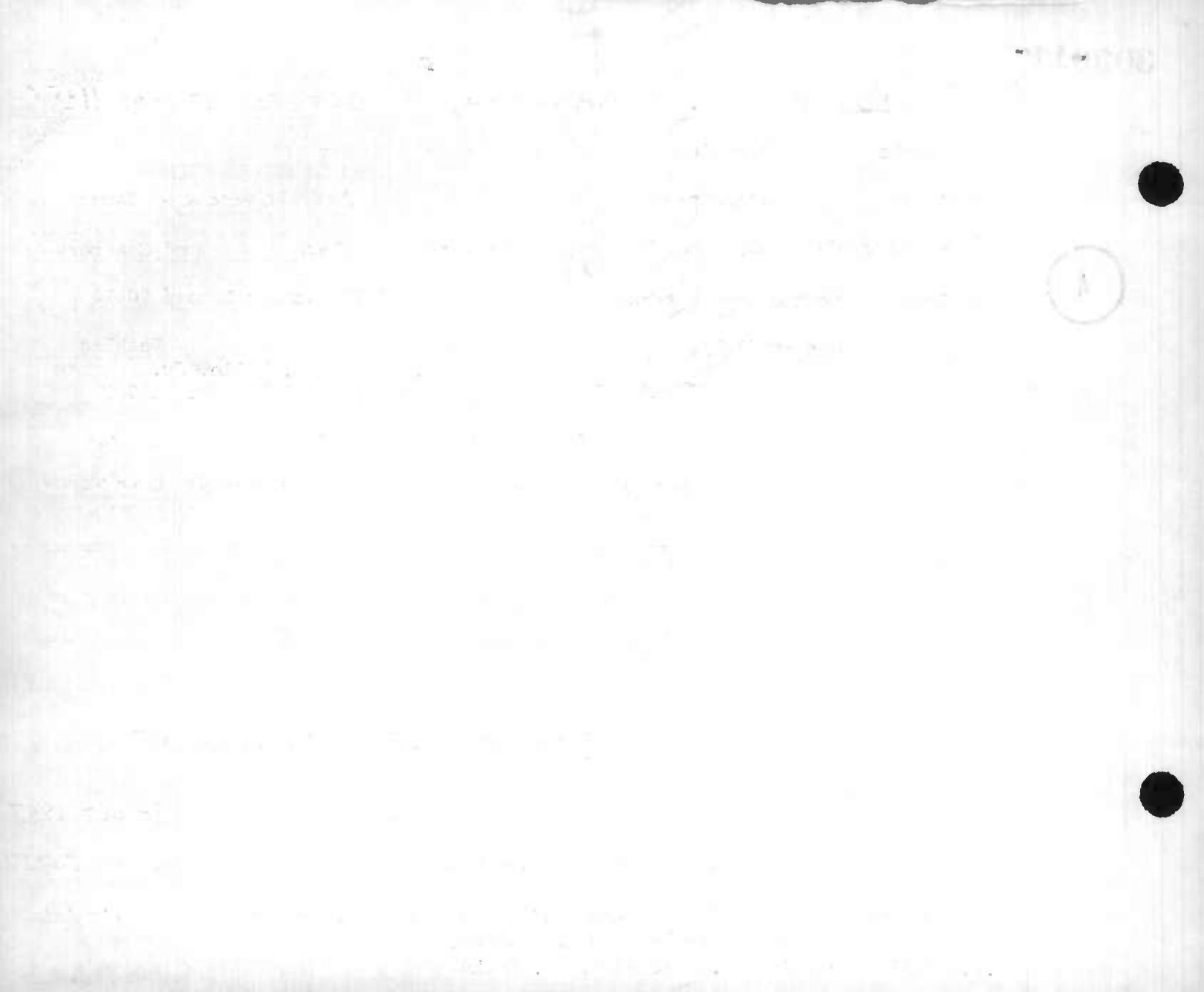
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed / filled in by the funeral director, page 3 should be detached for use as the Burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |             |                   |  |        |                                   |   |                           |  |   |  |         | 85 29031   |                           |  |                       |                                   |  |  |  |
|---|-------------|-------------------|--|--------|-----------------------------------|---|---------------------------|--|---|--|---------|--|---------------------------|--|-----------------------|-----------------------------------|--|--|--|
|   |             |                   |  |        |                                   |   |                           |  |   |  |         | REG. NO.   |                           |  |                       |                                   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |             |                   | FIRST  | MIDDLE | LAST                              | 2a. DATE OF DEATH   |                           |  |   | MONTH  | DAY     | YEAR   | 2b. HOUR                  |  |                       |                                   |  |  |  |
| LOUISE C. GANNAWAY  |             |                   |  |        |                                   | OCTOBER 27 1985   |                           |  |   |  |         |  | 1145 PM                   |  |                       |                                   |  |  |  |
| 3. SEX  |             |                   | 4. RACE  |        |                                   | 5. DATE OF BIRTH  |                           |  |   | 6. AGE (IN YEARS LAST BIRTHDAY)  |         |  | IF UNDER 1 YEAR           |  | IF UNDER 24 HRS       |                                   |  |  |  |
| Female  |             |                   | Caucasian  |        |                                   | August 23, 1898   |                           |  |   | 87   |         |  | YRS.                      |  | MONTHS DAYS HOURS MIN |                                   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |             |                   | 7b. CITIZEN OF WHAT COUNTRY?   |        |                                   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                           |  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH   |         |  | 10. CITY OR TOWN OF DEATH |  |                       |                                   |  |  |  |
| Illinois  |             |                   | United States  |        |                                   |   |                           |  |   | MONTGOMERY County, MD.   |         |  | TAKOMA PARK               |  |                       |                                   |  |  |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)   |             |                   |  |        |                                   |   |                           |  |   |  |         | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |                           |  |                       | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |  |
| HERITAGE HEALTH CARE CENTER   |             |                   |  |        |                                   |   |                           |  |   |  |         | Clerk  |                           |  |                       | Library of Congress               |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |             |                   |  |        |                                   |   |                           |  |   |  |         | 13e. STREET ADDRESS / ZIP CODE                                   |                           |  |                       |                                   |  |  |  |
| 13b. STATE  | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS?   |        |                                   |   | 4977 Battery Lane / 20814 |  |   |  |         |  |                           |  |                       |                                   |  |  |  |
| Maryland  | Montgomery  | Bethesda          | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>    |        |                                   |   |                           |  |   |  |         |  |                           |  |                       |                                   |  |  |  |
| 14. FATHER'S NAME<br>FIRST  |             |                   | MIDDLE   | LAST   | 15. MOTHER'S MAIDEN NAME<br>FIRST |   |                           |  | MIDDLE                                      | LAST   | Peebles |  |                           |  |                       |                                   |  |  |  |
| Not available   |             |                   |  |        | Augusta                           |   |                           |  |   |  |         |  |                           |  |                       |                                   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |             |                   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)                |        |                                   | 17. INFORMANT Mr. William P. Poole, Jr., Nephew<br>ADDRESS<br>9301 Lynmont Dr., Adelphi, MD. 20783  |                           |  |   |  |         |  |                           |  |                       |                                   |  |  |  |
| No  |             |                   | 220-44-3718  |        |                                   |   |                           |  |   |  |         |  |                           |  |                       |                                   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)   |             |                   |  |        |                                   |   |                           |  |   |  |         | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>SUDDEN        |                           |  |                       |                                   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE   |             |                   |  |        |                                   |   |                           |  |   |  |         | UNKNOWN  |                           |  |                       |                                   |  |  |  |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause last.<br>(c)  |             |                   |  |        |                                   |   |                           |  |   |  |         |  |                           |  |                       |                                   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |             |                   |  |        |                                   |   |                           |  |   |  |         |  |                           |  |                       |                                   |  |  |  |
| 19a. DATE OF OPERATION  |             |                   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |        |                                   |   | 20a. AUTOPSY?             |  |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |         |  |                           |  |                       |                                   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |             |                   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |        |                                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |                           |  |   |  |         |  |                           |  |                       |                                   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>   |             |                   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |        |                                   | 21f. LOCATION<br>STREET   |                           |  | CITY OR TOWN                                | COUNTY   | STATE   |  |                           |  |                       |                                   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 9 AUGUST 1985 to 27 OCTOBER 1985, that (I) (we) last<br>saw the deceased alive on 27 OCTOBER 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |             |                   |  |        |                                   |   |                           |  |   |  |         | 22c. DATE SIGNED<br>28 OCT. 1985                                 |                           |  |                       |                                   |  |  |  |
| 22b. SIGNATURE<br>CARL J. HOUmann   |             |                   | DEGREE   |        |                                   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                          |                           |  |   |  |         |  |                           |  |                       |                                   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>CARL J. HOUmann M.D.   |             |                   | 22e. ADDRESS<br>4404 QUEENSBURY RD RIVERDALE MD 20737                  |        |                                   |   |                           |  |   |  |         |  |                           |  |                       |                                   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation   |             |                   | 23b. DATE<br>October 28, 1985  |        |                                   | 23c. NAME OF CEMETERY OR CREMATORIAL<br>Metropolitan Crematory  |                           |  | 23d. LOCATION<br>CITY OR TOWN<br>Alexandria |  |         | COUNTY   | STATE                     |  |                       |                                   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>P.A., 7557 Wisconsin Ave., Bethesda, MD. 20814  |             |                   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 01 1985                           |        |                                   | 25b. REGISTRAR'S SIGNATURE<br>John Miller, Jr.  |                           |  |   |  |         |  |                           |  |                       |                                   |  |  |  |
| DHMH - 16 50M 4/83<br>(VRA 15, 4)   |             |                   |  |        |                                   |   |                           |  |   |  |         |  |                           |  |                       |                                   |  |  |  |



303077

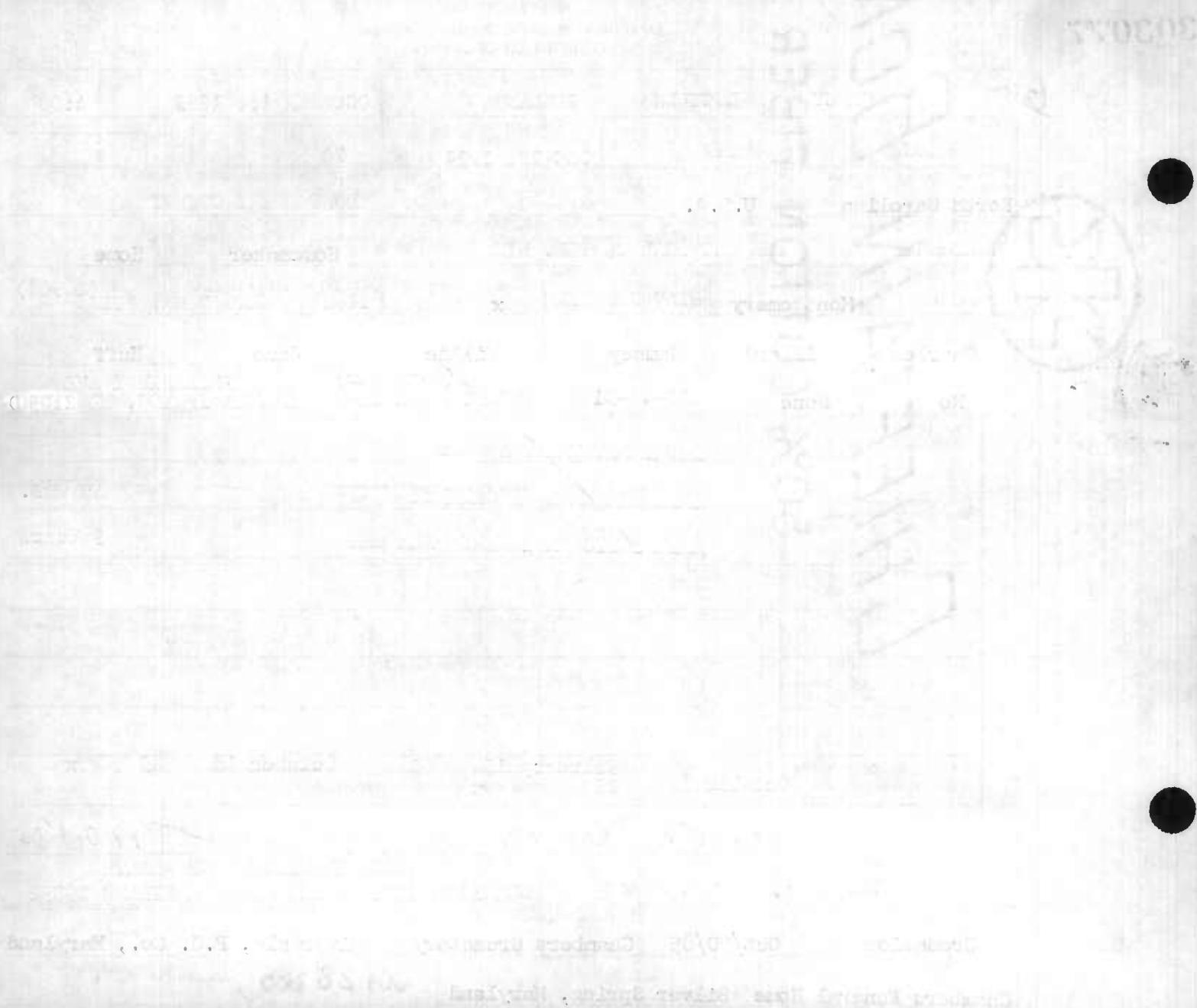
TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical certifier must sign below.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |  |  |  |  |  |   |  |  | 8529032   |  |  |                                   |  |  |                           |  |                          |  |
|---|--|--|---|--|--|--|--|--|---|--|--|---|--|--|-----------------------------------|--|--|---------------------------|--|--------------------------|--|
|   |  |  |   |  |  |  |  |  |   |  |  | REG. NO.  |  |  |                                   |  |  |                           |  |                          |  |
| 1 - FOR STATE REGISTRAR   |  |  | I - DECEASED NAME<br>(TYPE OR PRINT)  |  |  | FIRST NANCY  |  |  | MIDDLE LUCILLE  |  |  | LAST GARLAND  |  |  | 2a DATE OF DEATH OCTOBER 18, 1985 |  |  | 2b HOUR 4:00 P.M.         |  |                          |  |
| 3. SEX FEMALE   |  |  | 4. RACE WHITE   |  |  | 5. DATE OF BIRTH<br>MONTH DEC 28, 1914   |  |  | DAY   |  |  | YEAR  |  |  | 6. AGE 70 YRS                     |  |  | IF UNDER 1 YEAR<br>MONTHS |  | IF UNDER 24 HRS<br>HOURS |  |
| 7a BIRTHPLACE<br>COUNTRY North Carolina   |  |  | 7b CITIZEN OF WHAT COUNTRY? U.S.A.  |  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY COUNTY MD.  |  |  |   |  |  |                                   |  |  |                           |  |                          |  |
| 10 CITY OR TOWN OF DEATH<br>BETHESDA  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE CLINICAL CENTER, NIH |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker   |  |  | 12b KIND OF BUSINESS OR INDUSTRY<br>Home  |  |  |   |  |  |                                   |  |  |                           |  |                          |  |
| 13a STATE<br>MARYLAND   |  |  | 13b COUNTY<br>Montgomery  |  |  | 13c CITY OR TOWN<br>SILVER SPRING  |  |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  | 13e STREET ADDRESS / ZIP CODE<br>11621 LOCKWOOD DR, #T1 (20904) |  |  |                                   |  |  |                           |  |                          |  |
| 14 FATHER'S NAME<br>FIRST Charles   |  |  | MIDDLE Willard  |  |  | LAST Ramsey  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST Willie  |  |  | MIDDLE Jane   |  |  | LAST Huff                         |  |  |                           |  |                          |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  |  | 16b SOCIAL SECURITY NO.<br>None   |  |  | 17 INFORMANT (daughter)<br>BELINDA PHILLIPS  |  |  | ADDRESS<br>400 MISSISSIPPI AVE<br>SILVER SPRING, MD 20910   |  |  |   |  |  |                                   |  |  |                           |  |                          |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and 1c.)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST  |  |  |   |  |  |  |  |  |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                 |  |  |                                   |  |  |                           |  |                          |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) INTRACEREBRAL HEMORRHAGE  |  |  |   |  |  |  |  |  |   |  |  | 48 HRS.   |  |  |                                   |  |  |                           |  |                          |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) METASTATIC MALIGNANT MELANOMA   |  |  |   |  |  |  |  |  |   |  |  | 9 Years   |  |  |                                   |  |  |                           |  |                          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a  |  |  |   |  |  |  |  |  |   |  |  |   |  |  |                                   |  |  |                           |  |                          |  |
| 19a DATE OF OPERATION   |  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  | 20b IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |   |  |  |                                   |  |  |                           |  |                          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)   |  |  |   |  |  |   |  |  |                                   |  |  |                           |  |                          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>   |  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  | 21f LOCATION<br>STREET   |  |  | CITY OR TOWN  |  |  | COUNTY STATE  |  |  |                                   |  |  |                           |  |                          |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from February 15, 1982, to October 18, 1985, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on October 18, 1985, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did not view the body after death. |  |  |   |  |  |  |  |  |   |  |  |   |  |  |                                   |  |  |                           |  |                          |  |
| 22b. SIGNATURE<br>Kenneth Kern MD   |  |  | 22c. DEGREE   |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                            |  |  | 22d. DATE SIGNED<br>19 Oct '85  |  |  |   |  |  |                                   |  |  |                           |  |                          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Kenneth Kern MD  |  |  | 22e ADDRESS<br>NATIONAL INSTITUTES OF HEALTH<br>CLINICAL CENTER, BETHESDA, MARYLAND 20892   |  |  |  |  |  |   |  |  |   |  |  |                                   |  |  |                           |  |                          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation   |  |  | 23b. DATE<br>Oct/20/85  |  |  | 23c. NAME OF CEMETERY OR CREMATORIAL<br>Chambers Crematory   |  |  | 23d. LOCATION<br>CITY OR TOWN<br>Riverdale, P.G. Co., Maryland  |  |  | COUNTY STATE  |  |  |                                   |  |  |                           |  |                          |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Chambers Funeral Home   |  |  | ADDRESS<br>Silver Spring, Maryland  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 28 1985   |  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |  |  |   |  |  |                                   |  |  |                           |  |                          |  |
| BP _____  |  |  |   |  |  |  |  |  |   |  |  |   |  |  |                                   |  |  |                           |  |                          |  |
| DHMH - 16 60M 7/84<br>(VRA 15, 4)   |  |  |   |  |  |  |  |  |   |  |  |   |  |  |                                   |  |  |                           |  |                          |  |

57060



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 may be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked, Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |   |  |      | 8529033                              |   |                 |                   |                  |                               |          |  |
|--|--|---|--|---|--|--|---|--|------|--------------------------------------|---|-----------------|-------------------|------------------|-------------------------------|----------|--|
|  |  |   |  |   |  |  |   |  |      | REG. NO.                             |   |                 |                   |                  |                               |          |  |
| 1 - STATE REGISTRAR  |  | 1a. DECEASED NAME<br>(TYPE OR PRINT)  |  |   | FIRST  |  | MIDDLE  |  | LAST |                                      | 2a. DATE OF DEATH                               |                 | MONTH             | DAY              | YEAR                          | 2b. HOUR |  |
|  |  | MEREDITH HUNTER GARVER  |  |   |  |  |   |  |      |                                      | OCTOBER 22 1985                                 |                 |                   |                  |                               | 11:49 P  |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH  |  |  |   |  |      | 6. AGE (IN YEARS LAST BIRTHDAY)      |   | IF UNDER 1 YEAR |                   | IF UNDER 24 HRS. |                               |          |  |
| FEMALE   |  | CAUCASIAN   |  | JUNE 15 1929  |  |  |   |  |      | 56                                   |   | MONTHS          |                   | DAYS             |                               | HOURS    |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |  |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |      | 9. BALTIMORE CITY OR COUNTY OF DEATH |   |                 |                   |                  |                               |          |  |
| WYOMING  |  | UNITED STATES   |  |   |  |  |   |  |      | MONTGOMERY County,                   |   |                 |                   |                  |                               |          |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                 |  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |      |                                      |   |                 |                   |                  |                               |          |  |
| BETHESDA   |  | NAVAL HOSPITAL  |  |   | HOUSEWIFE  |  |   | Own Home   |      |                                      |   |                 |                   |                  |                               |          |  |
| 13a. STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  |  | 13d. INSIDE CITY LIMITS?  |  |      | 13e. STREET ADDRESS / ZIP CODE       |   |                 |                   |                  |                               |          |  |
| MARYLAND   |  | MONTGOMERY  |  | BETHESDA  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |      | 6777 SURREYWOOD LANE 20817           |   |                 |                   |                  |                               |          |  |
| 14. FATHER'S NAME<br>FIRST   |  | MIDDLE  |  | LAST  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST                                   |  |      | MIDDLE                               |   | LAST            |                   |                  |                               |          |  |
| HERBERT M. HUNTER  |  |   |  |   |  |  | EUGENIA WORTH LUTZ  |  |      |                                      |   |                 |                   |                  |                               |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   |  |   | 16c. INFORMANT   |  |   | ADDRESS  |      |                                      |   |                 |                   |                  |                               |          |  |
| NO   |  | 500-26-0773   |  |   | Husband  |  |   | JOHN B. GARVER, JR., 6777 SURREYWOOD LANE.   |      |                                      |   |                 |                   |                  |                               |          |  |
| 18. CAUSE OF DEATH<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)  |  |   |  |   | BETHESDA, MD 20817   |  |   |  |      |                                      | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |                 |                   |                  |                               |          |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |  | { (b)   |  |   |  |  |   |  |      |                                      |   |                 |                   |                  |                               |          |  |
|  |  | { (c)   |  |   |  |  |   |  |      |                                      |   |                 |                   |                  |                               |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |  |   |  |  |   |  |      |                                      |   |                 |                   |                  |                               |          |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?  |  |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?  |      |                                      |   |                 |                   |                  |                               |          |  |
|  |  |   |  |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>              |  |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |      |                                      |   |                 |                   |                  |                               |          |  |
| 21a. ACCIDENT WAS UNDERLYING<br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |   | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |  |   |  |      |                                      |   |                 |                   |                  |                               |          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)                                     |  |   | 21f. LOCATION<br>STREET  |  |   | CITY OR TOWN   |      |                                      | COUNTY  |                 | STATE             |                  |                               |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from SEPTEMBER 6, 1985, to OCTOBER 22, 1985, that (I) (we) last saw the deceased alive on OCTOBER 22, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. |  |   |  |   |  |  |   |  |      |                                      |   |                 |                   |                  | 22c. DATE SIGNED<br>23 Oct 85 |          |  |
| 22b. SIGNATURE<br><i>J. H. Edmunds</i> MD  |  |   |  |   | DEGREE   |  |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |      |                                      |   |                 |                   |                  |                               |          |  |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT)<br>J. H. EDMUND, LT, MC, USN   |  |   |  |   | 22d. ADDRESS   |  |   | NAVAL HOSPITAL, NAVAL MEDICAL COMMAND,<br>NATIONAL CAPITAL REGION, BETHESDA, MD 20814  |      |                                      |   |                 |                   |                  |                               |          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 23b. DATE<br>Oct. 28, 1985  |  |   | 23c. NAME OF CEMETERY OR CREMATORIAL<br>West Point Cemetery                      |  |   | 23d. LOCATION<br>CITY OR TOWN<br>West Point  |      |                                      | COUNTY  |                 | STATE<br>New York |                  |                               |          |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>P.A., 7557 Wisconsin Ave. Bethesda, Maryland   |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br>OCT 28 1985                                     |  |   | 25b. REGISTRAR'S SIGNATURE<br><i>John Shaver, Jr.</i>  |      |                                      |   |                 |                   |                  |                               |          |  |
|  |  |   |  |   |  |  |   |  |      |                                      |   |                 |                   |                  |                               |          |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be forwarded within 24 hours after death, except as may be  
retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3  
should be detached for use as the burial/transit permit. Then please remove carbon copies. If item 2 is marked, the filer within 24 hours after death  
with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

305083

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 29034

REG. NO.

|   |  |  |   |  |  |   |               |  |  |  |   |  |   |  |  |  |
|---|--|--|---|--|--|---|---------------|--|--|--|---|--|---|--|--|--|
| 1 - STATE REGISTRAR   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR                            |  |  |   |               |  | 2b. HOUR   |  |   |  |   |  |  |  |
| I. DECEASED NAME FIRST MIDDLE LAST  |  |  | OCTOBER 25 1985   |  |  | 7:20 PM   |               |  |  |  |   |  |   |  |  |  |
| 1. SEX MALE   |  | 4. RACE CAUCASIAN  |   | 5. DATE OF BIRTH MONTH MARCH DAY 8 YEAR 1922   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 63                |               |  | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.  |  |   |  |   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) OHIO  |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY   |               |  | 10. CITY OR TOWN OF DEATH BETHESDA   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED Pilot |  | 12b. KIND OF BUSINESS OR INDUSTRY U.S. AIR FORCE |  |
| 13a. STATE MARYLAND   |  |  | 13b. COUNTY MONTGOMERY                                      |  |  | 13c. CITY OR TOWN CHEVY CHASE                     |               |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   | 13e. STREET ADDRESS / ZIP CODE 4620 N. PARK AVE #1001W 20815 |   |  |  |  |
| 14. FATHER'S NAME FIRST JOHN MIDDLE SEBASTIAN LAST GIEL   |  |  | 15. MOTHER'S MAIDEN NAME FIRST MARY MIDDLE MAE LAST FRIEDEL |  |  |   |               |  |  |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN)   |  |  | 16b. SOCIAL SECURITY NO. 1940-1964                          |  |  | 17. INFORMANT LOUISE M. GIEL                      |               |  | 18. ADDRESS 4620 N. PARK AVE #1001W  |  |   |  |   |  |  |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)   |  |  | END STAGE LIVER DISEASE                                     |  |  |   |               |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |  |  | (b) ALCOHOLIC CIRRHOSIS                                     |  |  |   |               |  |  |  |   |  |   |  |  |  |
| (c)   |  |  | DUE TO, OR AS A CONSEQUENCE OF                              |  |  |   |               |  |  |  |   |  |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |   |  |  |   |               |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |  |  |   | 20a. AUTOPSY? |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?                               |  |   |  |   |  |  |  |
| YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |               |  |  |  |   |  |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |               |  |  |  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |               |  |  |  |   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from OCTOBER 23, 1985, to OCTOBER 25, 1985, that (I) (we) lost<br>sow the deceased alive on OCTOBER 25, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |   |  |  |   |               |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE  |  | 22c. DEGREE  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                       |  | 22d. DATE SIGNED OCTOBER 26 85                    |               |  |  |  |   |  |   |  |  |  |
| 22d. PHYSICIAN'S NAME D. JOHNSON, LCDR, MC, USN   |  | 22e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND<br>NATIONAL CAPITAL REGION, BETHESDA, MD. 20814 |   |  |  |   |               |  |  |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation   |  | 23b. DATE 10/29/85   |   | 23c. NAME OF CEMETERY OR CREMATORIAL Mt. Comfort Cem.  |  | 23d. LOCATION CITY OR TOWN Alex., VA COUNTY STATE |               |  |  |  |   |  |   |  |  |  |
| 24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc.<br>NAME 5130 WI Ave. NW Wash., DC 20016   |  |  |   |  |  |   |               |  |  |  |   |  |   |  |  |  |
| 25a. DATE REC'D. BY REGISTRAR OCT 30 1985   |  | 25b. REGISTRAR'S SIGNATURE   |   |  |  |   |               |  |  |  |   |  |   |  |  |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - STATE  
REGISTRAR

|  |   |  |                                   |   |   |  |  |                                     |                                |   |                               |  |
|--|---|--|-----------------------------------|---|---|--|--|-------------------------------------|--------------------------------|---|-------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |   |  | FIRST                             | MIDDLE  | LAST  | 2a. DATE OF DEATH  | MONTH  | DAY                                 | YEAR                           | 2b. HOUR  |                               |  |
| <i>EDITH</i>   |   |  | <i>m</i>                          |   | <i>GILBERT</i>                                    | <i>10</i>  | <i>24</i>  | <i>85</i>                           | <i>746 PM</i>                  |   |                               |  |
| 3. SEX   | 4. RACE   |  |                                   | 5. DATE OF BIRTH<br>MONTH DAY YEAR  |   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |                                     |                                | IF UNDER 1 YEAR<br>MONTHS DAYS                  | IF UNDER 24 HRS<br>HOURS MIN. |  |
| <i>Female</i>  | <i>Caucasian</i>  |  |                                   | <i>November 23, 1919</i>  |   |  | <i>65</i>  |                                     |                                |   |                               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?  |  |                                   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |                                     |                                | MD.   |                               |  |
| <i>New York</i>  | <i>USA</i>  |  |                                   |   |   |  | <i>Montgomery</i>  |                                     |                                | <i>Citizens</i>                                 |                               |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                                   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |                                     |                                | MD.   |                               |  |
| <i>Silver Spring</i>   | <i>Holy Cross Hospital</i>  |  |                                   | <i>Controller Ass't. Bank &amp; Trust</i>   |   |  |  |                                     |                                | <i>Bank &amp; Trust</i>                         |                               |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |   |  |                                   |   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                     | 13e. STREET ADDRESS / ZIP CODE |   |                               |  |
| 13a. STATE   | 13b. COUNTY   | 13c. CITY OR TOWN  |                                   |   |   | <i>4515 Gridley Road</i>   |  |                                     | <i>20906</i>                   |   |                               |  |
| <i>Marlboro</i>  | <i>Montgomery</i>   | <i>Silver Spring</i>   |                                   |   |   |  |  |                                     |                                |   |                               |  |
| 14. FATHER'S NAME<br>FIRST   | MIDDLE  | LAST   | 15. MOTHER'S MAIDEN NAME<br>FIRST |   |   | MIDDLE   | LAST   |                                     |                                |   |                               |  |
| <i>James</i>   | <i>K.</i>   | <i>Nehmens</i>   | <i>Edith</i>                      |   |   |  |  |                                     |                                |   |                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   | 16b. SOCIAL SECURITY NO.  |  |                                   | 17. INFORMANT   |   |  | ADDRESS  |                                     |                                | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |                               |  |
| <i>No</i>  | <i>102 09 6070</i>  |  |                                   | <i>Clifford Gilbert Husband</i>   |   |  | <i>Same as 13</i>  |                                     |                                | <i>2 years</i>                                  |                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)  |   |  |                                   |   |   | <i>CARDIOPULMONARY ARREST</i>  |  |                                     |                                |   |                               |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>CIRRHOSIS</i>   |   |  |                                   |   |   | <i>2 years</i>   |  |                                     |                                |   |                               |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>HEPATO RENAL SYNDROME</i>   |   |  |                                   |   |   | <i>1 week</i>  |  |                                     |                                |   |                               |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a  |   |  |                                   |   |   |  |  |                                     |                                |   |                               |  |
| 19a. DATE OF OPERATION<br><i>9/20/85</i>   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>ASCITES, PLEURAL FISTULA</i>                       |  |                                   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>              |                                     |                                |   |                               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |                                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)  |   |  |  |                                     |                                |   |                               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  |                                   | 21f. LOCATION<br>STREET   |   |  | CITY OR TOWN   |                                     |                                | COUNTY  | STATE                         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>8/28</i> , 19 <i>85</i> , to <i>10/24</i> , 19 <i>85</i> that (I) (we) last saw the deceased alive on <i>10/24</i> , 19 <i>85</i> . and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. |   |  |                                   |   |   |  |  |                                     |                                |   |                               |  |
| 22b. SIGNATURE<br><i>John Diamond</i>  |   |  |                                   |   |   | DEGREE<br><i>MD</i>  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED<br><i>10/24/85</i> |                                |   |                               |  |
| 22d. PHYSICIAN'S NAME (THE SAME)<br><i>John Diamond</i>  |   |  |                                   |   |   | 22e. ADDRESS<br><i>1100 Spruce St, Silver Spring MD</i>                              |  |                                     |                                |   |                               |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>  | 23b. DATE<br><i>10/28/85</i>  | 23c. NAME OF CEMETERY OR CREMATORIAL<br><i>Fort Lincoln Cemetery</i> |                                   |   | 23d. LOCATION<br>CITY OR TOWN<br><i>Brentwood</i> | STATE<br><i>Pr. Geo. Maryland</i>  |  |                                     |                                |   |                               |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Francis J. Collins, Jr.</i>   | ADDRESS<br><i>500 University Blvd., West Silver Spring, Md.</i>   | 25a. DATE REC'D. BY REGISTRAR<br><i>OCT 29 1985</i>                  |                                   |   | 25b. SIGNATURE<br><i>[Signature]</i>              |  |  |                                     |                                |   |                               |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and certified filled in by the funeral director, page 3 should be detached for use as the burial/transit's permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours after death.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

310073

|  |  |  |   |  |   |   |  |  |  |   |       |  |
|--|--|--|---|--|---|---|--|--|--|---|-------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  | WASHINGTON  | FIRST<br>MIDDLE<br>LAST  | GILL  | 2a DATE OF DEATH  | MONTH  | DAY  | YEAR   | 2b. HOUR                                    |       |  |
| 2. SEX<br>MALE   |  |  | 3. RACE<br>WHITE  | 4. DATE OF BIRTH<br>MONTH DAY YEAR<br>SEPT. 1, 1911  |   |   | 5. AGE (IN YEARS LAST BIRTHDAY)<br>74 YES          |  |  | 6. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN |       |  |
| 7a. BIRTHPLACE STATE OR FOREIGN<br>COUNTRY<br>PENN.  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                     | 7c. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |   | 8. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY |  |  | MD.   |       |  |
| 9. CITY OR TOWN OF DEATH:<br>ROCKVILLE   |  |  | 10. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>SHAW BAPTIST |  |   | 11. USUAL OCCUPATION<br>SECURITY GUARD  |  |  | 12. END OF BUSINESS OR<br>PLACE OF WORK (WORKING LIFE)<br>SHOPPING CENTER  |   |       |  |
| 13a. STATE<br>MD.  |  |  | 13b. COUNTY<br>MONT.  | 13c. CITY OR TOWN<br>ROCKVILLE   | 13d. INSIDE-CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  | 13e. STREET ADDRESS<br>205 E. Argyle St. #1 20850              |  |   |       |  |
| 14. FATHER'S NAME<br>FIRST<br>HARRY  |  |  | MIDDLE<br>E.  | LAST<br>GILL   | 15. MOTHER'S MAIDEN NAME<br>EMMA  |   |  | 16. ADDRESS<br>1962 E. Inverness Circle<br>Mesa, Arizona 85204 |  |   |       |  |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>YES  |  |  | 17b. SOCIAL SECURITY NO.<br>WWII  |  |   | 17c. INFORMANT<br>Tommy L. Gill   |  |  | 17d. APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>30 min   |   |       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)                         |  |  | 18c. DUE TO, OR AS A CONSEQUENCE OF<br>(b) Acute Myocardial Infarction  |  |   | 18d. DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |  | 18e. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).<br>PART 2 |   |       |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                        |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                      |   |       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19              |  |   | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |   |       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>                            |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |   | 21f. LOCATION<br>STREET   |  |  | CITY OR TOWN   | COUNTY                                      | STATE |  |
| 22a. I certify that (I) this hospital attended the deceased from<br>saw the deceased alive on above, (I) (did) (did not) view the body after death.      |  |  | 22b. DEGREE<br>Carl J. Schoenberger MD                                  |  |   | 22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  | 22d. DATE SIGNED<br>10/29/85   |   |       |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Carl J. Schoenberger  |  |  | 22e. ADDRESS<br>4701 Randolph Rd Rockville MD                           |  |   |   |  |  |  |   |       |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  |  | 23b. DATE<br>NOV. 1, 1985   |  |   | 23c. NAME OF CEMETERY OR CREMATORIAL<br>Arlington Nat'l Cem.  |  |  | 23d. LOCATION<br>Arlington County, Arlington Va.   |   |       |  |
| 24. FUNERAL DIRECTOR<br>FRANCIS H. B ARBER   |  |  | 24b. ADDRESS<br>LAYTONSVILLE, MD. 20879                                 |  |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 04 1985  |  |  | 25b. REGISTRAR'S SIGNATURE<br>John Burden-Randall  |   |       |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove the first two pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 18 is marked or if item 18 shows any injury, or other terminal event, the medical examiner must be notified at once.

| ITEM NUMBER 9b P.F.R.P.H.CALL<br>18-24-855 D.W.   |  |   |                | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |                                 |  |                 | 85 29037  |                 |   |  |
|---|--|---|----------------|---|---------------------------------|--|-----------------|---|-----------------|---|--|
| 1 - STATE REGISTRAR   |  |   |                |   |                                 |  |                 | REG. NO.  |                 |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST   | MIDDLE         | LAST  | 2d. DATE OF DEATH               |  | MONTH           | DAY   | YEAR            | 2b. HOUR  |  |
| Mabel Dungan  |  |   |                | Glicker   | 10-16-85                        |  |                 |   |                 | 3 A.M.  |  |
| 3. SEX  |  | 4. RACE   |                | 5. DATE OF BIRTH  | 6. AGE (IN YEARS LAST BIRTHDAY) |  | IF UNDER 1 YEAR |   | IF UNDER 24 HRS |   |  |
| Female  |  | White   |                | MONTH 3 DAY 24 YEAR 1919  | 66                              |  | MONTHS YRS      | MONTHS DAYS   | HOURS MIN.      |   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |                | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH   |                 |   |                 | MD.   |  |
| Va.   |  | U.S.  |                |   |                                 | Montgomery   |                 |   |                 |   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                |   |                                 | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |                 | 12b. KIND OF BUSINESS OR INDUSTRY   |                 |   |  |
| Takoma  |  | CWAH  |                |   |                                 | Homemaker  |                 | Own Home  |                 |   |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Prince Geo's   |                | 13c. CITY OR TOWN<br>Brentwood  |                                 | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                    |                 | 13e. STREET ADDRESS / ZIP CODE<br>3703 Quincy Street 20722  |                 |   |  |
| 14. FATHER'S NAME<br>Colus  |  | MIDDLE<br>Andrew  | LAST<br>Dungan | 15. MOTHER'S MAIDEN NAME<br>Annie   |                                 | MIDDLE<br>Agnes  | LAST<br>Burgess |   |                 |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>577-16-8115 A   |                | 17. INFORMANT<br>Marsha G. Benya  |                                 | ADDRESS<br>6039 Cipriano Road<br>Lanham, Maryland 20706  |                 |   |                 | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ASphyxia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Cancer of the Lung</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |   |                |   |                                 |  |                 |   |                 |   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Metastatic carcinoma to Brain, bone</u>  |  |   |                |   |                                 |  |                 |   |                 |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.<br><u>Cancer of the Bladder; Cancer Lung; Cancer Liver; Cancer</u>  |  |   |                |   |                                 |  |                 |   |                 |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                |   |                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                 |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |                                 |  |                 |   |                 |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |                | 21f. LOCATION<br>STREET   |                                 | CITY OR TOWN   |                 | COUNTY  |                 | STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/15 1985 to 10/16 1985, that (I) (we) last saw the deceased alive on 10/15 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.       |  |   |                |   |                                 |  |                 |   |                 |   |  |
| 22b. SIGNATURE<br>Robert Ruderman   |  | DEGREE<br>MD  |                |   |                                 | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                 | 22c. DATE SIGNED<br>10/16/85  |                 |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Robert Ruderman, MD  |  | 22e. ADDRESS<br>6510 Kenilworth Avenue, Riverdale   |                |   |                                 |  |                 |   |                 |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>10/18/1985   |                | 23c. NAME OF CEMETERY OR CREMATORIUM<br>Henderson Cemetery  |                                 | 23d. LOCATION<br>CITY OR TOWN<br>Hyacinth  |                 | COUNTY<br>Northumberland  |                 | STATE<br>VA.                                    |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>James J. Cole   |  | P.O. Box 276<br>Heathsville, VA.  |                |   |                                 | 25a. DATE REC'D. BY REGISTRAR<br>OCT 23 1985   |                 | 25b. REGISTRAR'S SIGNATURE<br>John L. Wilson, Jr.   |                 |   |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

29038

298109

FOR  
1 - STATE  
REGISTRAR

REG. NO.

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 25 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA-3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT BIRM. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESIDENT, BALTIMORE, MD. 21201 PRIOR TO BURIAL, CREMATION, OR REVENGEAL.

DIVISION OF VITAL RECORDS, 201 W. PRESIDENT, BALTIMORE, MD. 21201

## MEDICAL CERTIFICATION

|  |         |  |  |                                      |   |  |                                      |  |        |          |   |
|--|---------|--|--|--------------------------------------|---|--|--------------------------------------|--|--------|----------|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         |  | FIRST                                      | MIDDLE                               | LAST  | 2a. DATE KNOWN<br>OF DEATH<br>ESTIMATED<br>MATED                                     | MONTH                                | DAY  | YEAR   | 2b. HOUR |   |
| CORA GOLDER  |         |  |  |                                      |   | <input checked="" type="checkbox"/>  | 10-16-85,                            |  |        |          |   |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH<br>MONTH DAY YEAR   | 6. AGE (IN YEARS<br>LAST BIRTHDAY)<br>YRS. | 7. IF UNDER 1 YR.<br>MONTHS DAYS     | 8. IF UNDER 24 HRS.<br>HOURS MIN  | 2c. DATE<br>PRONOUNCED<br>DEAD   | MONTH                                | DAY  | YEAR   | 2d. HOUR |   |
| Female   | White   | 10 5 30  | 55   |                                      |   | 10-16-85,  |                                      |  |        | 11:33P   |   |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |  |                                      | 8. MARRIED<br>WIDOWED   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |        | MD.      |   |
| Ohio   |         | U.S.   |  |                                      | <input type="checkbox"/> NEVER MARRIED<br><input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | Montgomery County                    |  |        |          |   |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                                      | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)  |  |                                      | 12b. KIND OF BUSINESS<br>OR INDUSTRY             |        |          |   |
| Rockville  |         | 235 N. Van Buron St.   |  |                                      | Homemaker   |  |                                      |  |        |          |   |
| 13a. STATE<br>Md.  |         | 13b. COUNTY<br>Mtg.  |  | 13c. CITY OR TOWN<br>Rockville       |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                      | 13e. STREET ADDRESS<br>235 N. VanBuren St. 20850 |        |          |   |
| 14. FATHER'S NAME<br>FIRST<br>Max  |         | MIDDLE   |  | LAST<br>Glick                        |   | 15. MOTHER'S MAIDEN NAME<br>FIRST<br>Sarah   |                                      |  |        |          |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |         | 16b. SOCIAL SECURITY NO.   |  |                                      | 17. INFORMANT<br>N. E. - ADDRESS 610 E. Capitol St  |  |                                      |  |        |          |   |
| No   |         | 281-24-9917  |  |                                      | Ms. Nancy Golder Washington, D. C.  |  |                                      |  |        |          |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>amitriptyline intoxication</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a) stating the under-<br>lying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |         |  |  |                                      |   |  |                                      |  |        |          | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1<br>_____  |         |  |  |                                      |   |  |                                      |  |        |          |   |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |                                      | 20. AUTOPSY?<br>(PARTIAL)<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                |  |                                      |  |        |          |   |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>11pm 10/15 19   |  |                                      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>ingestion of drugs             |  |                                      |  |        |          |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE<br>AT WORK <input checked="" type="checkbox"/>  |         | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)<br>home                                     |  |                                      | 21f. LOCATION<br>STREET<br>235 N. Van Buren St.<br>CITY OR TOWN<br>Rockville, Md.<br>COUNTY<br>STATE            |  |                                      |  |        |          |   |
| 22a. I certify that I took charge of the remains described above, held an <u>(PARTIAL) <input checked="" type="checkbox"/></u> . Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion<br>death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>ACTUAL<br>SIGNATURE <u>Margarita Korell</u> M.D. Assistant MEDICAL EXAMINER |         |  |  |                                      |   |  |                                      |  |        |          | DATE<br>SIGNED 10-17-85                         |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |         | Margarita A. Korell, M.D.  |  |                                      | ADDRESS<br>111 Penn Street  |  |                                      |  |        |          |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |         | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORIUM |   |  | 23d. LOCATION<br>CITY OR TOWN        |  | COUNTY | STATE    |   |
| Removal  |         | 10/16/85   |  |                                      |   |  |                                      |  |        |          |   |
| 24. FUNERAL DIRECTOR<br>NAME   |         | ADDRESS  |  |                                      | 25a. DATE REC'D. BY REGISTRAR   |  |                                      | 25b. REGISTRAR'S SIGNATURE                       |        |          |   |
| Anatomy Board  |         | Balto., Md.  |  |                                      | OCT 24 1985   |  |                                      | <u>Jessie Davidson Pendell</u>                   |        |          |   |
| BP/1363  |         |  |  |                                      |   |  |                                      |  |        |          |   |
| DHMH - 17<br>(VR A15 ME (5))   |         |  |  |                                      |   |  |                                      |  |        |          |   |

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STANLEY

REGT POSITION



RECEIVED

317061

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other nonnatural event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |  |        |  |         |  |   | 8529039                |      |                                |          |                               |  |                               |  |   |  |  |  |  |  |
|--|--|--|---|--|--------|--|---------|--|---|------------------------|------|--------------------------------|----------|-------------------------------|--|-------------------------------|--|---|--|--|--|--|--|
|  |  |  |   |  |        |  |         |  |   | REG. NO.               |      |                                |          |                               |  |                               |  |   |  |  |  |  |  |
| 1 - FOR<br>STATE<br>REGISTRAR  |  |  | 2a. DATE OF DEATH   |  |        |  |         |  |   | MONTH                  | DAY  | YEAR                           | 2b. HOUR |                               |  |                               |  |   |  |  |  |  |  |
| I. DECEASED NAME<br>(TYPE OR PRINT)  |  |  | FIRST   |  | MIDDLE |  | LAST    |  | 10 - 31 - 85  |                        | 9:45 | PM                             |          |                               |  |                               |  |   |  |  |  |  |  |
| SAMUEL   |  |  |   |  |        |  | GOLDMAN |  |   |                        |      |                                |          |                               |  |                               |  |   |  |  |  |  |  |
| 3. SEX   |  |  | 4. RACE   |  |        | 5. DATE OF BIRTH   |         |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |                        |      | IF UNDER 1 YEAR<br>MONTHS DAYS |          | IF UNDER 24 HRS<br>HOURS MIN. |  |                               |  |   |  |  |  |  |  |
| Male   |  |  | White   |  |        | MONTH DAY YEAR<br>Aug. 2, 1908   |         |  | 77  |                        |      |                                |          |                               |  |                               |  |   |  |  |  |  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)  |  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  |        | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |         |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |                        |      | MD.                            |          |                               |  |                               |  |   |  |  |  |  |  |
| Russia   |  |  | USA   |  |        |  |         |  | MONTGOMERY  |                        |      |                                |          |                               |  |                               |  |   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |        | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |         |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |                        |      |                                |          |                               |  |                               |  |   |  |  |  |  |  |
| Rockville  |  |  | Hebrew Home of Greater Washington   |  |        | Dentist  |         |  | Dentistry   |                        |      |                                |          |                               |  |                               |  |   |  |  |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |   |  |        |  |         |  |   | 13a. STATE<br>Maryland |      |                                |          | 13b. COUNTY<br>Montgomery     |  | 13c. CITY OR TOWN<br>Bethesda |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET ADDRESS<br>4928 Sentinel Drive 20816 |  |  |
|  |  |  |   |  |        |  |         |  |   |                        |      |                                |          |                               |  |                               |  |   |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST<br>(unknown)  |  |  | MIDDLE  |  |        | LAST<br>Bernicka   |         |  | 15. MOTHER'S MAIDEN NAME<br>FIRST<br>Sophie   |                        |      | MIDDLE                         |          | LAST<br>Sures                 |  |                               |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   |  |        | 17. INFORMANT<br>ADDRESS<br>Bethesda, Md. 20816  |         |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) RESPIRATORY ARREST<br>APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>4 hours |                        |      |                                |          |                               |  |                               |  |   |  |  |  |  |  |
| Yes  |  |  | WW II   |  |        | 579-52-4466  |         |  | Florence Goldman; 4928 Sentinel Drive   |                        |      |                                |          |                               |  |                               |  |   |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.   |  |  | (b) ASPIRATION PNEUMONITIS  |  |        |  |         |  |   |                        |      |                                |          |                               |  |                               |  |   |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) ALZHEIMER'S DEMENTIA   |  |  |   |  |        |  |         |  |   |                        |      | 5 years                        |          |                               |  |                               |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a<br>OLD MI, SIP PARTIAL GASTRECTOMY, PLEURAL EFFUSION  |  |  |   |  |        |  |         |  |   |                        |      |                                |          |                               |  |                               |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |        | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |         |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                        |      |                                |          |                               |  |                               |  |   |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |        | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |         |  |   |                        |      |                                |          |                               |  |                               |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  |        | 21f. LOCATION<br>STREET<br>CITY OR TOWN<br>COUNTY<br>STATE   |         |  |   |                        |      |                                |          |                               |  |                               |  |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10/31/1985</u> , to <u>10/31/1985</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |   |  |        |  |         |  |   |                        |      |                                |          |                               |  |                               |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br>Stanley Cutler, M.D.   |  |  |   |  |        |  |         |  |   | DEGREE                 |      | 22c. DATE SIGNED<br>11-1-85    |          |                               |  |                               |  |   |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>STANLEY CUTLER  |  |  | 22e. ADDRESS<br>6121 MONTROSE ROAD<br>ROCKVILLE, MARYLAND 20852   |  |        | ATTENDING<br>PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF<br>PHYSICIAN <input checked="" type="checkbox"/>        |         |  |   |                        |      |                                |          |                               |  |                               |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>SPECIES<br>Burial   |  |  | 23b. DATE<br>11-3-1985  |  |        | 23c. NAME OF CEMETERY OR CREMATORIAL<br>Falls Church, Va.  |         |  | 23d. LOCATION<br>CITY OR TOWN<br>COUNTY<br>STATE  |                        |      |                                |          |                               |  |                               |  |   |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Danzansky-Goldberg Chapels; 1170 Rockville Pike  |  |  | 25a. ADDRESS<br>Rockville, Md.  |  |        | 25b. DATE REC'D. BY REGISTRAR<br>NOV 6 1985  |         |  | 25b. REGISTRAR'S SIGNATURE<br>Julian J. Fisher  |                        |      |                                |          |                               |  |                               |  |   |  |  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached as the burial/transit permit. Then please remove Part I of this certificate and attach it to the burial/transit permit. It should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the deceased.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause of death, the medical examiner must be notified at once.

297014

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 29040

1 - STATE REGISTRAR

REG. NO.

|  |   |   |        |  |  |                    |   |   |  |             |                   |   |                                |
|--|---|---|--------|--|--|--------------------|---|---|--|-------------|-------------------|---|--------------------------------|
| I. DECEASED NAME<br>(TYPE OR PRINT)  |   |   | FIRST  | MIDDLE   | LAST   | 20. DATE OF DEATH  | MONTH   | DAY   | YEAR   | 2b HOUR     |                   |   |                                |
| BLUMA  |   |   |        |  | GOLDSMAN   | 10. 16. 85.        |   |   |  | 4:30 P.M.   |                   |   |                                |
| 3. SEX   | 4. RACE   | 5. DATE OF BIRTH  |        |  | 6. AGE (IN YEARS LAST BIRTHDAY)  | 7. IF UNDER 1 YEAR |   |   | 8. IF UNDER 24 HRS   |             |                   |   |                                |
| FEMALE   | WHITE   | NOVEMBER 15, 1898   |        |  | 86   | MONTHS             | DAYS  | HOURS   | YRS.   |             |                   |   |                                |
| 7a. BIRTHPLACE<br>COUNTRY  | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |        |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |                    |   | MD.   |  |             |                   |   |                                |
| RUSSIA   | U.S.A.  |   |        |  | MONTGOMERY COUNTY  |                    |   |   |  |             |                   |   |                                |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |        | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  |                    | 12b. KIND OF BUSINESS OR INDUSTRY                                   |   |  |             |                   |   |                                |
| ROCKVILLE  | HEBREW HOME OF GREATER WASHINGTON HOUSEWIFE   |   |        |  |  |                    | OWN HOME  |   |  |             |                   |   |                                |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |   |   |        |  |  | 13a. STATE         |   |   |  | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS / ZIP CODE |
|  |   |   |        |  |  | MARYLAND           |   |   |  | MONTGOMERY  | SILVER SPRING     | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 1400 FENWICK LANE 20910        |
| 14. FATHER'S NAME  | FIRST   | MIDDLE  | LAST   | 15. MOTHER'S MAIDEN NAME   |  |                    | FIRST   | MIDDLE  | LAST   |             |                   |   |                                |
| NATHAN   |   |   | MAZIER | SARA   |  |                    |   |   | HOLTZMAN   |             |                   |   |                                |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(IF NO OR UNKNOWN)   | 16b. SOCIAL SECURITY NO.  | 17. INFORMANT   |        |  | 9508 SEMINOLE STREET   |                    |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |             |                   |   |                                |
| NO   | 578-24-8344D  | CELIA KELLER, SILVER SPRING, MARYLAND   |        |  |  |                    |   |   |  |             |                   |   |                                |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY  |   |   |        |  |  |                    |   |   |  |             |                   |   |                                |
| IMMEDIATE CAUSE (a) <u>Coma, Respiratory arrest,</u>   |   |   |        |  |  |                    |   |   |  |             |                   |   |                                |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Diabetes / Hypertension - Cerebrovascular accident</u>  |   |   |        |  |  |                    |   |   |  |             |                   |   |                                |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |   |   |        |  |  |                    |   |   |  |             |                   |   |                                |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Congestive heart failure</u>  |   |   |        |  |  |                    |   |   |  |             |                   |   |                                |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |   |   |        |  |  |                    |   |   |  |             |                   |   |                                |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |        |  |  |                    | 20a. AUTOPSY?   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |             |                   |   |                                |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR   |        |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |                    | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |             |                   |   |                                |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |        |  | 21f. LOCATION<br>STREET  |                    | CITY OR TOWN  |   | COUNTY   |             | STATE             |   |                                |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>117</u> , 19 <u>85</u> , to <u>10/16</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>10. 16. 19 85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |   |        |  |  |                    |   |   |  |             |                   |   |                                |
| 22b. SIGNATURE<br><u>J. Goldsman</u>   |   | 22c. DEGREE<br>M.D.   |        |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                    |   | DATE SIGNED<br><u>10. 16. 85.</u>               |  |             |                   |   |                                |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |   | 22e. ADDRESS  |        |  | 6111 Executive Blvd, Rockville MD.   |                    |   |   |  |             |                   |   |                                |
| 23a. BURIAL, CREMATION, REMOVAL  |   | 23b. DATE   |        |  | BETH SHOLOM SYNAGOGUE  |                    |   | CAPITOL CEMETERY                                |  |             |                   |   |                                |
| BURIAL   |   | 10/18/1985  |        |  |  |                    |   |   |  |             |                   |   |                                |
| 24. FUNERAL DIRECTOR<br>NAME   |   | ADDRESS   |        |  | LOCATION   |                    |   | CITY  |  |             |                   |   |                                |
| DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME   |   |   |        |  | CAPITOL  |                    |   | PRINCE GEORGE'S                                 |  |             |                   |   |                                |
| 132 CARROLL STREET, N. W., WASHINGTON, D. C.   |   |   |        |  |  |                    |   | MARYLAND  |  |             |                   |   |                                |
| 25. DATE REC'D. BY REGISTRAR   |   |   |        |  |  |                    |   |   |  |             |                   |   |                                |
| OCT 21 1985  |   |   |        |  |  |                    |   |   |  |             |                   |   |                                |

11/15/02



290176

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the Burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or interment.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other trauma, a medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |   |   |                               |                               |  |  | 85 29041   |  |  |         |  |  |
|--|--|--|---|---|---|-------------------------------|-------------------------------|--|--|--|--|--|---------|--|--|
|  |  |  |   |   |   |                               |                               |  |  | REG. NO.   |  |  |         |  |  |
| 1. FOR STATE REGISTRAR   |  | 1. DECEASED NAME<br>(TYPE OR PRINT)                                    |   |   | FIRST PRIMITIVO MIDDLE Primitive  |                               | LAST GONZALEZ                 |  | 2d. DATE OF DEATH  | MONTH  | DAY  | YEAR   | 2d HOUR |  |  |
| 3. SEX   |  | MALE   | 4. RACE   | WHITE   | 5. DATE OF BIRTH  |                               |                               | MONTH  | DAY  | YEAR   | 16 9 85 1727PM   |  |         |  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)  |  | MEXICO   | 7b. CITIZEN OF WHAT COUNTRY?  |   |   | 8                             |                               |  | MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY       |  |  |         |  |  |
| 10. CITY OR TOWN OF DEATH  |  | TAKOMA PARK  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(NAME OF HOSPITAL, NURSING HOME, ETC. GIVE STREET ADDRESS) |   |   | WASHINGTON ADVENTIST HOSPITAL |                               |  | 12a. USUAL OCCUPATION<br>(NAME OF WORK FOR MOST OF WORKING LIFE)   |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>FARMING              |         |  |  |
| 13a. STATE   |  | MARYLAND   | 13b. COUNTY   |   | PRINCE GEORGES BELTSVILLE   | 13c. CITY OR TOWN             |                               |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 13e. STREET ADDRESS / ZIP CODE<br>3409 CHERRY HILL CT. 20705 |         |  |  |
| 14. FATHER'S NAME  |  | FIRST ABRAM  | MIDDLE  |   | LAST GONZALEZ   | 15. MOTHER'S MAIDEN NAME      |                               |  | FIRST MARIA  | MIDDLE   |  | LAST SOTO  |         |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | NO   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR ORDERS)   |   |   | 17. INFORMANT                 |                               |  | ADDRESS<br>GINA GONZALEZ, DAUGHTER, SAME AS ITEM #13   |  |  |  |         |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)  |  |  |   |   |   |                               |                               |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>weeks |  |  |         |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Inoperable Aortic stenosis</u>  |  |  |   |   |   |                               |                               |  |  | years -  |  |  |         |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) <u>and mitral insufficiency</u>   |  |  |   |   |   |                               |                               |  |  |  |  |  |         |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>metabolic neuropathy and renal failure</u>   |  |  |   |   |   |                               |                               |  |  |  |  |  |         |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?   |                               |                               | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/><br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |         |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2) |                               |                               |  |  |  |  |  |         |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET   |                               |                               | CITY OR TOWN   |  | COUNTY   |  | STATE  |         |  |  |
| 22a. I certify that (I) <u>this hospital</u> attended the deceased from <u>9/10</u> , 19 <u>85</u> , to <u>10/9</u> , 19 <u>85</u> , that (I) <u>lost</u><br>saw the deceased alive on <u>10/9</u> , 19 <u>85</u> , and that in (my) <u>no</u> opinion death occurred on the date and hour and from the causes stated<br>above, (I) <u>lost</u> did not view the body after death. |  |  |   |   |   |                               |                               |  |  |  |  |  |         |  |  |
| 22b. SIGNATURE<br><u>Frederick C. Brennwald MD</u>   |  |  |   |   |   |                               |                               |  |  | DEGREE   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED<br>10/10/85                                 |         |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS<br><u>F. C. BRENNWALD</u>                                 |   |   | 831 University Blvd E Silver Spring   |                               |                               |  |  |  |  |  |         |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORIAL<br>ADDRESS |   |                               | 23d. LOCATION<br>CITY OR TOWN |  | 23e. COUNTY  |  | 23f. STATE   |  |         |  |  |
| BURIAL   |  | 10/11/85   |   | GEORGE WASHINGTON CEM.                          |   |                               | ADELPHI                       |  | PG   |  | MD.  |  |         |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>1804 T ST., N.W., WASHINGTON, D.C. 20009   |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 16 1985                           |   |   | 25b. REGISTRAR'S SIGNATURE<br><u>J. Richard Rapp</u>                          |                               |                               |  |  |  |  |  |         |  |  |
| DHMH - 16 60M 7/84<br>(VRA 15, 4)  |  |  |   |   |   |                               |                               |  |  |  |  |  |         |  |  |

35-2083

1917-1918

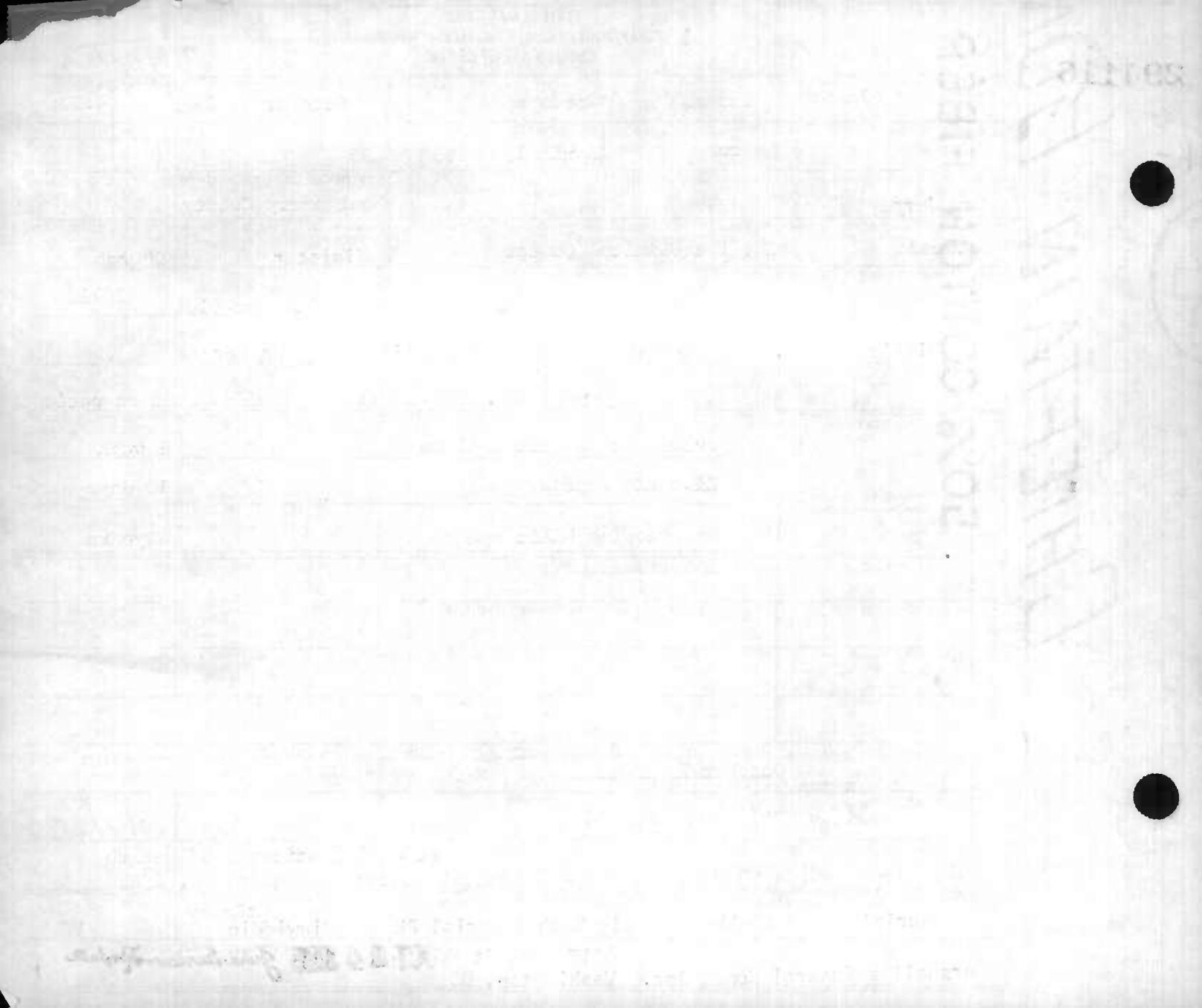
TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or interment.

IMPORTANT: If item 18 is marked or item 18 shows any injury or other trauma, it must be certified by a medical examiner.

294116

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |  |  |   |  |  |  |  |  | REG. NO. 29042   |               |                               |                        |
|--|--|--|---|--|--|---|--|--|--|--|--|--|---------------|-------------------------------|------------------------|
| 1 - FOR<br>STATE<br>REGISTRAR  |  |  | FIRST<br>Jesse  |  |  | MIDDLE<br>Thomas  |  |  | LAST<br>Goodwyn  |  |  | 2a DATE OF DEATH<br>October 7, 1985                        | MONTH<br>YEAR | DAY<br>YEAR                   | 2b HOUR<br>4:50 P<br>M |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  |   |  |  |   |  |  |  |  |  |  |               |                               |                        |
| 3. SEX<br>Male   |  |  | 4. RACE<br>Negro  |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>April 15 1950   |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>35 YRS.   |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS                             |               | IF UNDER 24 HRS<br>HOURS MIN. |                        |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New Jersey  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County MD.  |  |  |  |               |                               |                        |
| 10. CITY OR TOWN OF DEATH<br>Bethesda  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>NIH, The Clinical Center |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Minister  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Church  |  |  |  |               |                               |                        |
| 13a. STATE<br>Maryland   |  |  | 13b. COUNTY<br>M.D.   |  |  | 13c. CITY OR TOWN<br>Bladensburg  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |  | 13e. STREET ADDRESS / ZIP CODE<br>5028 57th Ave #101 20710 |               |                               |                        |
| 14. FATHER'S NAME<br>FIRST<br>William  |  |  | MIDDLE<br>C.  |  |  | LAST<br>Goodwyn   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST<br>Peacolia  |  |  | MIDDLE<br>Walker   |               |                               |                        |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>no  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>226-68-3311  |  |  | 17. INFORMANT<br>Mrs. Barbara Goodwyn, wife, same as patient  |  |  | ADDRESS  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>1 week  |               |                               |                        |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Fulminant hepatic failure<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Listeria sepsis<br>10 days<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.<br>(c) Hypereosinophilic syndrome<br>4 years  |  |  |   |  |  |   |  |  |  |  |  |  |               |                               |                        |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a   |  |  |   |  |  |   |  |  |  |  |  |  |               |                               |                        |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |               |                               |                        |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)   |  |  |  |  |  |  |               |                               |                        |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  | 21f. LOCATION<br>STREET<br>CITY OR TOWN<br>COUNTY<br>STATE  |  |  |  |  |  |  |               |                               |                        |
| 22a. I certify that (1) (this hospital) attended the deceased from September 30, 1985, to October 7, 1985, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on October 7, 1985, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> view the body after death. |  |  |   |  |  |   |  |  |  |  |  |  |               |                               |                        |
| 22b. SIGNATURE<br>Philip M. Murphy MD  |  |  | DEGREE  |  |  | 22c. DATE SIGNED<br>10/7/85   |  |  |  |  |  |  |               |                               |                        |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Philip M. Murphy MD   |  |  | 22e. ADDRESS<br>National Institutes of Health<br>Clinical Center, Bethesda, Md. 20892   |  |  |   |  |  |  |  |  |  |               |                               |                        |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |  | 23b. DATE<br>10-11-85   |  |  | 23c. NAME OF CEMETERY OR CREMATORIUM<br>Big Bethel Burial Pk  |  |  | 23d. LOCATION<br>CITY OR TOWN<br>McKenny<br>COUNTY<br>Dinwiddie  |  |  | STATE<br>VA  |               |                               |                        |
| 24. FUNERAL DIRECTOR<br>NAME<br>Marshall's Funeral Home, Inc.  |  |  | ADDRESS<br>4217 9th St NW   |  |  | 25. THE C.D. BY MEDICAL REGISTRAR'S SIGNATURE<br>OCT. 14, 1985 John Anderson, Jr.   |  |  |  |  |  |  |               |                               |                        |
| (VRA 15, 4)  |  |  |   |  |  |   |  |  |  |  |  |  |               |                               |                        |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and certified by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be retained within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked check to show any injury, or other traumatic event, the medical certifying physician must sign below.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |                                   |  |   |  |   |  |                           | REG. NO.<br>8529043                 |
|---|--|---|-----------------------------------|--|---|--|---|--|---------------------------|-------------------------------------|
| 1 - FOR<br>STATE<br>REGISTRAR   |  |   |                                   |  |   |  |   |  |                           |                                     |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST<br><b>SYLVIA</b>  | MIDDLE<br><b>M.</b>               | LAST<br><b>GORBAN</b>  | 2a. DATE OF DEATH<br><b>OCTOBER 23, 1985</b>  |  | MONTH<br>DAY<br>YEAR  | 2b. HOUR<br><b>9:00 P.M.</b>   |                           |                                     |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>WHITE</b>   |                                   | 5. DATE OF BIRTH<br><b>SEPTEMBER 7, 1907</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b>   |   | IF UNDER 1 YEAR<br>MONTHS<br>YRS   |                           |                                     |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                                   | 7c. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY COUNTY</b>                     |   | # UNDER 24 HRS<br>HOURS<br>MIN.  |                           |                                     |
| 10. CITY OR TOWN OF DEATH<br><b>SILVER SPRING</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><b>9515 CAROLINE AVENUE</b>  |                                   | 12a. USUAL OCCUPATION<br><b>HOUSEWIFE</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>OWN HOME</b>                                 |   | MD.<br><b>20901</b>  |                           |                                     |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><b>MARYLAND MONTGOMERY SILVER SPRING</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                   | 13e. STREET ADDRESS / ZIP CODE<br><b>9515 CAROLINE AVENUE</b>  |   |  |   |  |                           |                                     |
| 14. FATHER'S NAME<br>HARRY FIRST  |  | MIDDLE<br>MANEKIN   | 15. MOTHER'S MAIDEN NAME<br>CLARA |  | 16. SOCIAL SECURITY NO.<br><b>216-58-7931</b> |  | 17. INFORMANT<br><b>LAWRENCE D. GORBAN, 9515 CAROLINE AVENUE<br/>SILVER SPRING, MD.</b> |  | ADDRESS<br><b>2118/85</b> |                                     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <i>Carcinoma of Colon - metastasis</i>  |  | DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause, if any. |                                   | DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |   |  |   |  |                           |                                     |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><i>ASCO Post CVA</i>  |  |   |                                   |  |   |  |   |  |                           |                                     |
| 19a. DATE OF OPERATION<br><b>2/21/85</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>Ca of Colon</i>  |                                   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                           |                                     |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |   |  |                           |                                     |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)   |                                   | 21f. LOCATION<br>STREET  |   | CITY OR TOWN   |   | COUNTY   | STATE                     |                                     |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/17</b> , 19 <b>72</b> , to <b>10/23</b> , 19 <b>85</b> , that (I) (we) lost<br>saw the deceased alive on <b>10/17</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) did (did not) view the body after death. |  |   |                                   |  |   |  |   |  |                           | 22c. DATE SIGNED<br><b>10/24/85</b> |
| 22b. SIGNATURE<br><i>Marvin Schneider, M.D.</i>   |  | DEGREE  |                                   | ATTENDING<br>PHYSICIAN <input type="checkbox"/>  |   | MEDICAL<br>DIRECTOR <input type="checkbox"/>   |   | STAFF<br>PHYSICIAN <input type="checkbox"/>  |                           |                                     |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. MARVIN SCHNEIDER, M. D.</b>   |  | 22e. ADDRESS<br><b>12001 FERRARA AVENUE, WHEATON, MARYLAND</b>  |                                   |  |   |  |   |  |                           |                                     |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>  |  | 23b. DATE<br><b>10/25/1985</b>  |                                   | 23c. NAME OF CEMETERY OR CREMATORIAL<br><b>KING DAVID MEMORIAL GARDEN</b>  |   | 23d. LOCATION<br>ORTOWNSHIP<br><b>FALLS CHURCH, VIRGINIA</b>                         |   |  |                           |                                     |
| 24. FUNERAL DIRECTOR<br><b>DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME<br/>232 CARROLL STREET, N. W., WASHINGTON, D. C.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 28 1985</b>   |                                   | 25b. REGISTRAR'S SIGNATURE<br><i>Jessie Davidson, R.N.</i>   |   |  |   |  |                           |                                     |

20200



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial/transit permit. Then please remember to file item 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, record the medical name of the medical professional involved.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   | 8529044  |  |  |   |
|--|--|---|--|---|--|--|--|---|
|  |  |   |  |   | REG. NO.   |  |  |   |
| 1 - FOR STATE REGISTRAR  | FIRST  | MIDDLE  | LAST   | 2d DATE OF DEATH  | MONTH DAY YEAR   | 2b HOUR  |  |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  | Mary   | E.  | Graham   | 10  | 08 85  | 2:24AM   |  |   |
| 3. SEX   | Female   | RACE  | White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR  | July 1 1909  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>IF UNDER 1 YEAR<br>MONTHS DAYS  | 76 YRS   | IF UNDER 24 HRS<br>HOURS MIN.                           |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | Virginia   | 7b. CITIZEN OF WHAT COUNTRY?  | U.S.A.   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery   |  |   |
| 10. CITY OR TOWN OF DEATH  | Olney  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   | Montgomery General Hospital  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   | Housewife  | 12b. KIND OF BUSINESS OR INDUSTRY                       |
| 13a. STATE   | Md.  | 13b. COUNTY   | Montgomery                                     | 13c. CITY OR TOWN   | Gaithersburg   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            | 13e. STREET ADDRESS / ZIP CODE<br>324D - Diamond Ave. (East) 20877 |   |
| 14. FATHER'S NAME  | John   | MIDDLE  | William  | LAST  | Exie   | 15. MOTHER'S MAIDEN NAME   | C.   | LAST  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   | No   | 16b. SOCIAL SECURITY NO.  | 215-26-0826                                    | 17. INFORMANT   | Charles F. Graham  | ADDRESS  | 1203 Matthew Dr.<br>Rockville, Md. 20851                           | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>20 min. |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardio-pulmonary arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Rupturing aneurysm</u> 36 hrs.<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) |  |   |  |   |  |  |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |  |   |  |  |  |   |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                             |  |   |  |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET   | CITY OR TOWN                                   | COUNTY  | STATE  |  |  |   |
| 22a. I certify that (I) (his hospital) attended the deceased from <u>Oct. 6 1985</u> to <u>Oct. 8 1985</u> , that (I) (we) last saw the deceased alive on <u>Oct. 7 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did not view the body after death.                    |  |   |  |   |  |  |  |   |
| 22b. SIGNATURE <u>Frederick Moomau, M.D.</u> DEGREE  |  |   |  |   |  |  |  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Frederick Moomau, M.D.</u>   |  |   |  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22e. DATE SIGNED<br><u>10-8-85</u>   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   | 23b. DATE<br>Burial 10/10/85   | 23c. NAME OF CEMETERY OR CREMATORIAL<br>Forest Oak Cemetery   | 23d. LOCATION<br>CITY OR TOWN<br>Gaithersburg  | 23e. COUNTY<br>Montg.   | 23f. STATE<br>Md.  |  |  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>Gartner Sandison</u>  | 316 ADDRESS<br>Diamond Ave.,<br>Gaithersburg, Md. 20877                | 24a. DATE REC'D. BY REGISTRAR<br><u>OCT 14 1985</u>   | 24b. REGISTRAR SIGNATURE<br><u>J. Anderson</u> |   |  |  |  |   |
| DHMH - 16 60M 7/84<br>(VRA 15, 4)  |  |   |  |   |  |  |  |   |

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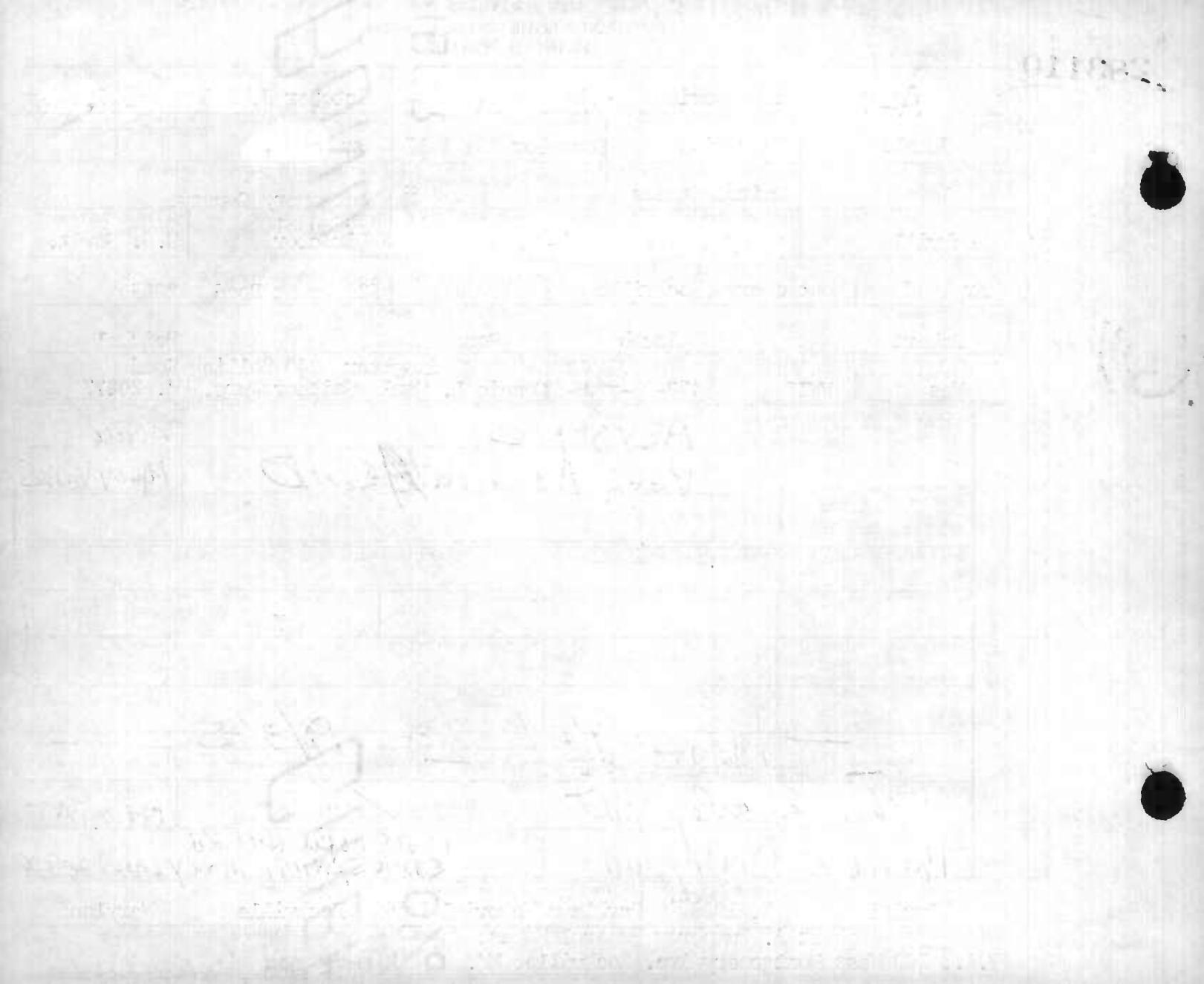
10. HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked on item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |  |  |  |  |  |  | 85 29045  |   |                                  |                 |          |  |
|--|--|--|---|--|--|--|--|--|--|---|---|----------------------------------|-----------------|----------|--|
|  |  |  |   |  |  |  |  |  |  | REG. NO.  |   |                                  |                 |          |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  | MIDDLE  |  |  | LAST   |  |  | 2a. DATE OF DEATH  |   | MONTH   | DAY                              | YEAR            | 2b. HOUR |  |
| Alvina Marie   |  |  |   |  |  | Hagedorn   |  |  | October 3, 1985  |   |   |                                  |                 | 12:41pm  |  |
| 3. SEX<br>Female   |  |  | 4. RACE<br>Caucasian  |  |  | 5. DATE OF BIRTH<br>Month Day Year<br>December 22, 1917  |  |  | 6. AGE (IN YEARS) / BIRTHDAY   |   | IF UNDER 1 YEAR   |                                  | IF UNDER 24 HRS |          |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Iowa   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>United States   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED<br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |  | 67   |   | YEARS<br>MONTHS DAYS  |                                  | HOURS MIN.      |          |  |
| 10. CITY OR TOWN OF DEATH<br>Rockville   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>Shady Grove Adventist Hospital |  |  | 12. USUAL OCCUPATION<br>Personnel Director   |  |  | 9. BALTIMORE CITY & COUNTY OF DEATH<br>Montgomery County, MD.  |   | 13. KIND OF BUSINESS OR INDUSTRY<br>U.S. Gov't.   |                                  |                 |          |  |
| 13a. STATE<br>Maryland   |  |  | 13b. COUNTY<br>Montgomery   |  |  | 13c. CITY OR TOWN<br>Rockville   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                      |   | 13e. STREET ADDRESS / ZIP CODE<br>529 Brent Road 20850  |                                  |                 |          |  |
| 14. FATHER'S NAME<br>First Robert  |  |  | Middle MIDDLE   |  |  | Last Jacob   |  |  | 15. MOTHER'S MAIDEN NAME<br>First Rosa   |   | Middle LAST Peichel   |                                  |                 |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  |  |  | 16b. SOCIAL SECURITY NO.<br>WWII  |  |  | 16c. ADDRESS<br>5283 470-03-5328   |  |  | 17. INFORMANT<br>daughter Connie L. Maul   |   | ADDRESS<br>240 Rolling Road Gaithersburg, Md. 20877   |                                  |                 |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |  |   |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>ACUTE |   |                                  |                 |          |  |
| (b)<br><br>DUE TO, OR AS A CONSEQUENCE OF<br>Very Advanced ASHD  |  |  |   |  |  |  |  |  |  | Ninny Years   |   |                                  |                 |          |  |
| (c)<br><br>DUE TO, OR AS A CONSEQUENCE OF  |  |  |   |  |  |  |  |  |  |   |   |                                  |                 |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |   |  |  |  |  |  |  |   |   |                                  |                 |          |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 19c. AUTOPSY?  |  |  | 20. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |   |                                  |                 |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |   |   |                                  |                 |          |  |
| 22a. INJURY OCCURRED<br>AT HOME <input type="checkbox"/> NOT AT HOME <input type="checkbox"/><br>AT WORK <input type="checkbox"/>  |  |  | 22b. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                    |  |  | 22c. LOCATION<br>STREET  |  |  | CITY OR TOWN   | COUNTY  | STATE   |                                  |                 |          |  |
| 23a. I certify that (i) this hospital attended the deceased from 9/25/85 to 10/3/85, and that in (my) opinion death occurred on the date and hour and from the causes stated above. (ii) (we) did not view the body after death.     |  |  |   |  |  |  |  |  |  | 23b. DATE SIGNED<br>Oct. 3, 1985                      |   |                                  |                 |          |  |
| 23c. SIGNATURE<br>Thomas E. Dosley, MD   |  |  |   |  |  |  |  |  |  | DEGREE  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 23d. DATE SIGNED<br>Oct. 3, 1985 |                 |          |  |
| 23e. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Thomas E. Dosley, MD  |  |  | 23f. ADDRESS<br>1717 Chapel Hill Rd<br>Silver Spring, Maryland 20910                      |  |  | 23g. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |  | 23h. DATE REC'D. BY REGISTRAR<br>OCT 8 1985  |   | 23i. REGISTRAR'S SIGNATURE<br>Julia Daviden Dosley  |                                  |                 |          |  |
| 24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Homes,<br>NAME ADDRESS<br>P.A., 300 West Montgomery Ave. Rockville, Md.  |  |  |   |  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 8 1985           |   | 25b. REGISTRAR'S SIGNATURE       |                 |          |  |



288033

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at Item 18 shows any injury, or other traumatic event, the medical examiner must be notified or else

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |        |      |  |        |          |  |        | 8 5 2 9 0 4 6 |  |   |  |
|--|--|---|--------|------|--|--------|----------|--|--------|---------------|--|---|--|
|  |  |   |        |      |  |        |          |  |        | REG. NO.      |  |   |  |
| 1 - FOR STATE REGISTRAR  |  | 1. DECEASED NAME<br>(TYPE OR PRINT)   |        |      | FIRST  | MIDDLE | LAST     | 20. DATE OF DEATH<br>MONTH DAY YEAR  |        |               | 2b. HOUR<br>8 <sup>00</sup> M  |   |  |
|  |  | Bella   |        |      |  |        | Halebsky | OCTOBER 1 1985   |        |               |  |   |  |
| 3. SEX   |  | 4. RACE   |        |      | 5. DATE OF BIRTH<br>JANUARY 1 1896   |        |          | 6. AGE (IN YEARS LAST BIRTHDAY)<br>89 YRS.   |        |               | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |   |  |
| FEMALE   |  | WHITE   |        |      |  |        |          |  |        |               |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |        |      | 8  |        |          | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.   |        |               |  |   |  |
| POLAND   |  | U.S.A.  |        |      | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |        |          | 10. CITY OR TOWN OF DEATH<br>Rockville   |        |               | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>HEBREW HOME OF GREATER WASHINGTON |   |  |
| 13a. STATE<br>MARYLAND   |  | 13b. COUNTY<br>MONTGOMERY   |        |      | 13c. CITY OR TOWN<br>ROCKVILLE   |        |          | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |        |               | 13e. STREET ADDRESS<br>6717 MONTROSE ROAD -- 20852   |   |  |
| 14. FATHER'S NAME<br>NATHANIEL   |  | FIRST   | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME<br>ROSE   |        |          | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>NO (NO OR UNKNOWN)   |        |               | 16b. SOCIAL SECURITY NO.<br>109-16-7079  |   |  |
|  |  |   |        |      |  |        |          |  |        |               | 17. INFORMANT<br>ALEXANDER B. WINICK, BETHESDA, MARYLAND   |   |  |
|  |  | ADDRESS<br>8304 WESTMONT TERRACE  |        |      |  |        |          |  |        |               |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
|  |  | PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) congestive HEART FAILURE  |        |      |  |        |          |  |        |               |  |   |  |
|  |  | DUE TO, OR AS A CONSEQUENCE OF<br>(b) metastatic BREAST CANCER  |        |      |  |        |          |  |        |               |  |   |  |
|  |  | Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |        |      |  |        |          |  |        |               |  |   |  |
|  |  | DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |        |      |  |        |          |  |        |               |  |   |  |
|  |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>INTRACRANIAL ESOPHAGOGAL REFLUX |        |      |  |        |          |  |        |               |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |        |      | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |        |          | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |        |               |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |        |      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |        |          |  |        |               |  |   |  |
| 21d. INJURY OCCURRED<br>WHITE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)   |        |      | 21f. LOCATION<br>STREET  |        |          | CITY OR TOWN   | COUNTY | STATE         |  |   |  |
| 22a. I certify that (I/this hospital) attended the deceased from JANUARY 2, 1985, to OCT 1, 1985, that (I/we) last saw the deceased alive on OCTOBER 1, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. |  |   |        |      |  |        |          |  |        |               |  |   |  |
| 22b. SIGNATURE<br>James A. Rossi   |  | 22c. DEGREE<br>MD   |        |      | ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                       |        |          | 22d. DATE SIGNED<br>10-2-85  |        |               |  |   |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br>JAMES A. ROSSI, MD  |  | 22f. ADDRESS<br>6717 EXECUTIVE BLVD.<br>ROCKVILLE MARYLAND 20852  |        |      |  |        |          |  |        |               |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>CREMATION.  |  | 23b. DATE<br>10/3/1985  |        |      | 23c. NAME OF CEMETERY OR CREMATORIAL<br>CEDAR HILL CREMATORIAL   |        |          | 23d. LOCATION<br>SUITLAND, PR. GEORGES, MARYLAND   |        |               |  |   |  |
| 24. FUNERAL DIRECTOR<br>DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME<br>232 CARROLL STREET, N. W., WASHINGTON, D. C.   |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 7 1985   |        |      |  |        |          |  |        |               |  |   |  |
|  |  | 25b. REGISTRAR'S SIGNATURE<br>Julia L. Jordan-Rodgers   |        |      |  |        |          |  |        |               |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death cert. can be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be deposited for use at the Bureau funeral parlor. Then please remove carbon copy from page 2 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to Burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other human event, the medical examiner must be notified.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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|  |  |  |   |   |   |   |   |   |  |  |   |        |       |
|--|--|--|---|---|---|---|---|---|--|--|---|--------|-------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  | FIRST<br><b>Hilda</b>   | MIDDLE<br><b>B.</b>   | LAST<br><b>Halford</b>  | 2a. DATE OF DEATH<br>MONTH<br><b>October</b>  | DAY<br><b>15, 1985</b>  | YEAR<br>1985                                    | REG. NO.   |  |   |        |       |
| 1. SEX<br><b>Female</b>  |  |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH<br><b>May</b>   | DAY<br><b>25, 1898</b>  | YEAR<br>1898  | 6. AGE<br>IN YEARS LAST BIRTHDAY<br><b>87</b>   | IF UNDER 1 YEAR<br>MONTHS<br><b>YRS</b>                            | IF UNDER 24 HRS<br>HOURS<br><b>3:00 p.m.</b>                         |   |        |       |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>MD</b>  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8<br>MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b>  |   |   | MD.  |  |   |        |       |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring</b>  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Chevy Chase Retirement &amp; Nursing Ctr.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Receptionist</b>   |   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>CIA</b> |  |  |   |        |       |
| 13a. STATE<br><b>DC</b>  |  |  | 14b. COUNTY<br><b>None</b>  | 13c. CITY OR TOWN<br><b>Washington</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   | 13e. STREET ADDRESS / ZIP CODE<br><b>4801 CT Ave. NW 99999</b>  |   |   |  |  |   |        |       |
| 14. FATHER'S NAME<br>FIRST<br><b>Joseph</b>  |  |  | MIDDLE<br><b>Brooks</b>   | LAST  | 15. MOTHER'S MAIDEN NAME<br>FIRST<br><b>Catherine</b>   | MIDDLE  | LAST<br><b>Lavin</b>  | ADDRESS<br><b>20815</b>                         |  |  |   |        |       |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES OR UNKNOWN)<br><b>No</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>577-4-9851</b>   |   | 17. INFORMANT<br><b>Angela M. McArdle</b>   | 18. CAUSE OF DEATH<br>Enter only one cause per line for Part I.<br>PART I: DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a)<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br><b>Acute Circ of arrest<br/>from<br/>arteriosclerotic heart disease</b> |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>terminal</b> |  |   |        |       |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                    |   |  |  |   |        |       |
| 21a. ACCIDENT WAS UNDERLYING<br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)<br><b>NOT WHILE AT WORK</b>   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)<br><b>fell</b> |   |   | 22a. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)<br><b>at work</b>   |   |  | 21d. LOCATION<br>STREET<br><b>8218 Wisconsin Ave</b>                 | CITY OR TOWN<br><b>Bethesda, Md. 20814</b>              | COUNTY | STATE |
| 22a. I certify that (1) <b>(the hospital)</b> attended the deceased from <b>9/29/85</b> , to <b>10/15/85</b> , that (1) <b>(the last</b><br>time the deceased alive on <b>9/29/85</b> , and that in (my) <b>(my)</b> opinion death occurred on the date and hour and from the causes stated<br>above. I also certify that the body after death |  |  | 22b. SIGNATURE<br><b>Joseph Gawler, MD</b>  |   |   | 22c. DATE SIGNED<br><b>10/15/85</b>   | 22d. ATTENDING<br>PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF<br>PHYSICIAN <input type="checkbox"/> |   |  |  |   |        |       |
| 22e. PHYSICIAN'S NAME<br>(TYPE OR PRINT)<br><b>J. Blawie, Jr., M.D.</b>  |  |  | 22f. ADDRESS<br><b>8218 Wisconsin Ave<br/>Bethesda, Md. 20814</b>   |   |   | 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE)<br><b>Burial</b>  |   |   | 23b. DATE<br><b>10/17/85</b>                                       | 23c. NAME OF CEMETERY OR CREMATORIAL<br><b>Arlington Nat'l. Cem.</b> | 23d. LOCATION<br>CITY OR TOWN<br><b>Arlington, Cem.</b> | COUNTY | STATE |
| 24. FUNERAL DIRECTOR<br><b>Joseph Gawler's Sons, Inc.</b><br><b>5130 WI Ave. NW Wash., DC 20016</b>  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 18 1985</b>   |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Joseph Gawler's Sons, Inc.</b>   |   |   |  |  |   |        |       |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove carbons. Page 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbons. Page 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or interment.

IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic event, the medical certification must be completed.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |   |      | 85 29048  |      |      |         |
|---|--|---|--|---|--|--|--|---|------|---|------|------|---------|
| 1 - STATE REGISTRAR   |  |   |  |   |  |  |  |   |      | REG. NO.  |      |      |         |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST   |  | MIDDLE  |  | LAST   |  | 2d. DATE OF DEATH   |      | MONTH   | DAY  | YEAR | 26 HOUR |
| KATHRYN M   |  |   |  |   |  | HALL   |  | 10  |      | 1   | 85   | 12P  | M       |
| 3. SEX  |  | RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | 7. IF UNDER 1 YEAR  |      | IF UNDER 24 HRS                                 |      |      |         |
| FEMALE  |  | CAUCASIAN   |  | MONTH DAY YEAR  |  | MONTH  |  | MONTHS  | DAYS | HOURS   | MIN. |      |         |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  | MD.   |      |   |      |      |         |
| VIRGINIA  |  | U.S.A.  |  | DEC 8, 1898   |  | MONTGOMERY   |  |   |      |   |      |      |         |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |      |   |      |      |         |
| Silver Spring   |  | Holy Cross Hospital   |  | SCHOOL TEACHER  |  | ST. ANTHONYS   |  |   |      |   |      |      |         |
| 13a. STATE  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                    |  | 13e. STREET ADDRESS / ZIP CODE  |      |   |      |      |         |
| MARYLAND  |  | MONTGOMERY  |  | SILVER SPRING   |  | YES <input checked="" type="checkbox"/>  |  | 8708 FIRST AVENUE 20910   |      |   |      |      |         |
| 14. FATHER'S NAME   |  | LAST  |  | 15. MOTHER'S MAIDEN NAME  |  | 16. SOCIAL SECURITY NO.  |  | ADDRESS   |      |   |      |      |         |
| DENNIS S.   |  | QUINN   |  | DOLLY J.  |  | 578-54-3395  |  | PARTICIA A. HALL SAME AS 13 DAUGHTER  |      |   |      |      |         |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT   |  | PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)  |  |   |      | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |      |      |         |
| NO  |  |   |  |   |  | Cardio Pulmonary Arrest  |  |   |      | 11 days   |      |      |         |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  | DUE TO, OR AS A CONSEQUENCE OF<br>(b) Shock   |  |   |  | DUE TO, OR AS A CONSEQUENCE OF<br>(c) Ruptured Aneurysm of Aorta   |  |   |      |   |      |      |         |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |  |   |  |  |  |   |      |   |      |      |         |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 19c. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |      |   |      |      |         |
| 9.21.85   |  | Ruptured Aneurysm of Aorta  |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>  |      |   |      |      |         |
| 21a. ACCIDENT WAS UNDERLYING<br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |   |      |   |      |      |         |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | P.M. 19   |  |   |  |  |  |   |      |   |      |      |         |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET   |  | CITY OR TOWN   |  | COUNTY  |      | STATE   |      |      |         |
| 22a. I certify that (I) (the hospital) attended the deceased from 9-25 19 85 to 10-1 19 85 that (I) (we) last saw the deceased alive on 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (do) (will do) what we could to help the deceased after death. |  |   |  |   |  |  |  |   |      |   |      |      |         |
| 22b. SIGNATURE  |  | 22c. DEGREE   |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | DATE SIGNED   |      |   |      |      |         |
| L. Alberto Nunez  |  | MD  |  |   |  |  |  | 10-1-85   |      |   |      |      |         |
| 22d. PHYSICIAN'S NAME AND TITLE OR PRINT  |  | 22e. ADDRESS  |  |   |  |  |  |   |      |   |      |      |         |
| Francis J. Collins  |  | 8218 Wisconsin Avenue, Bethesda   |  |   |  |  |  |   |      |   |      |      |         |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORIAL<br>ADDRESS   |  | 23d. LOCATION<br>CITY OR TOWN  |  | 23e. COUNTY   |      | STATE   |      |      |         |
| BURIAL  |  | 10/3/85   |  | HILLSBORO CEMETERY  |  | HILLSBORO  |  |   |      | VIRGINIA  |      |      |         |
| 24. FUNERAL DIRECTOR<br>NAME  |  | FRANCIS J. COLLINS  |  | ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |      |   |      |      |         |
|   |  |   |  |   |  | OCT 7 1985   |  | S. L. Smith   |      |   |      |      |         |
| DHMH - 16 60M 7/84<br>(VRA 15, 4)   |  | 500 UNTV BLVD., W., SILVER SPRING, MD. 20901  |  |   |  |  |  |   |      |   |      |      |         |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or interment.

IMPORTANT: If item 21 is marked "No" on Item 18 show any injury, or other traumatic event, the medical examiner will be called at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |                                  |      |  |                                 |  |   | 35  | 29   | 04              | 9            |       |
|--|--|--|---|----------------------------------|------|--|---------------------------------|--|---|---|--|-----------------|--------------|-------|
|  |  |  |   |                                  |      |  |                                 |  |   | REG. NO.  |  |                 |              |       |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  | FIRST   | MIDDLE                           | LAST | 2a. DATE OF DEATH  |                                 |  | MONTH   | DAY   | YEAR   | 2b. HOUR        |              |       |
| Mary Lee Hamilton  |  |  |   |                                  |      | 10 - 11 - 85   |                                 |  |   |   |  | 0308 A.M.       |              |       |
| 3. SEX   |  |  | RACE  | 5. DATE OF BIRTH                 |      |  | 6. AGE (IN YEARS LAST BIRTHDAY) |  |   | IF UNDER 1 YEAR                                 |  | IF UNDER 24 HRS |              |       |
| Female   |  |  | Black   | Month Day Year<br>April 13, 1943 |      |  | 42                              |  |   | MONTHS  | YEARS  | MONTHS          | HOURS        | MIN.  |
| 7a. BIRTHPLACE<br>COUNTRY  |  |  | 7b. CITIZEN OF WHAT COUNTRY?  |                                  |      | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                 |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY MD.                              |   |  |                 |              |       |
| Rockville MD   |  |  | USA   |                                  |      |  |                                 |  |   |   |  |                 |              |       |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                  |      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |                                 |  | 12b. KIND OF BUSINESS OR INDUSTRY   |   |  |                 |              |       |
| Shady Grove Adv. Hosp.   |  |  |   |                                  |      |  |                                 |  |   |   |  |                 |              |       |
| 13a. STATE<br>MD   |  |  | 13b. COUNTY<br>Montgomery   |                                  |      | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                                 |  | 13e. STREET ADDRESS/ ZIP CODE<br>19572 Scenery Dr/20874                             |   |  |                 |              |       |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |                                  |      |  |                                 |  |   |   |  |                 |              |       |
| William J. Barnes  |  |  | Margaret Simms  |                                  |      |  |                                 |  |   |   |  |                 |              |       |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |  |  | 16b. SOCIAL SECURITY NO.<br>253-44-4148   |                                  |      | 17. INFORMANT<br>John Hamilton (daughter) SAME AS #15  |                                 |  | ADDRESS   |   |  |                 |              |       |
| No   |  |  |   |                                  |      |  |                                 |  |   |   |  |                 |              |       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (o)                          |  |  |   |                                  |      |  |                                 |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |                 |              |       |
| respiratory failure.   |  |  |   |                                  |      |  |                                 |  |   | 229°  |  |                 |              |       |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause last.  |  |  |   |                                  |      |  |                                 |  |   | (b) ARDS (Adult Respiratory Distress Synd)      |  |                 |              |       |
| { DUE TO, OR AS A CONSEQUENCE OF<br>(c) Sepsis   |  |  |   |                                  |      |  |                                 |  |   | 224°  |  |                 |              |       |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |   |                                  |      |  |                                 |  |   | 29-98°  |  |                 |              |       |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).                      |  |  |   |                                  |      |  |                                 |  |   |   |  |                 |              |       |
| 21a. DATE OF OPERATION   |  |  | 21b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                  |      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |                                 |  | 20a. AUTOPSY<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                 |              |       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                                  |      | 21c.   |                                 |  |   |   |  |                 |              |       |
| 21d. INJURY OCCURRED<br>WHITE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>                            |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |                                  |      | 21f. LOCATION<br>STREET  |                                 |  | CITY OR TOWN  |   | COUNTY   |                 | STATE        |       |
| 22a. I certify that (I) this hospital attended the deceased from<br>saw the deceased alive on<br>above (I) (we) (did) did not view the body after death. |  |  | 20 - 10 - 85  |                                  |      | 19 - 85  |                                 |  | 10 - 10 - 85  |   | 19 - 85  |                 | 10 - 11 - 85 |       |
| 22b. SIGNATURE<br>Steven Polinsky  |  |  | 22c. DEGREE<br>MD   |                                  |      | 22d. ATTENDING PHYSICIAN<br><input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN   |                                 |  | 22e. DATE SIGNED<br>10/11/85  |   |  |                 |              |       |
| 22d. ATTENDING PHYSICIAN'S NAME<br>(TYPE OR PRINT)   |  |  | 22e. ADDRESS<br>15 E. Deer Pk Dr. Gaithersburg  |                                  |      |  |                                 |  |   |   |  |                 |              |       |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  |  | 23b. DATE<br>Burial 10-17-85  |                                  |      | 23c. NAME OF CEMETERY OR CREMATORIAL<br>Elijah Churcy Cem.   |                                 |  | 23d. LOCATION<br>CITY OR TOWN<br>Poolesville, Montg. MD                             |   |  | COUNTY          |              | STATE |
| 24. FUNERAL DIRECTOR<br>NAME   |  |  | ADDRESS<br>George R. Snowden Rockville, MD 20850  |                                  |      | 25a. DATE REC'D. BY REGISTRAR<br>10-16-85  |                                 |  | 25b. REGISTRAR'S SIGNATURE<br>John R. Snowden                                       |   |  |                 |              |       |

08130





294032

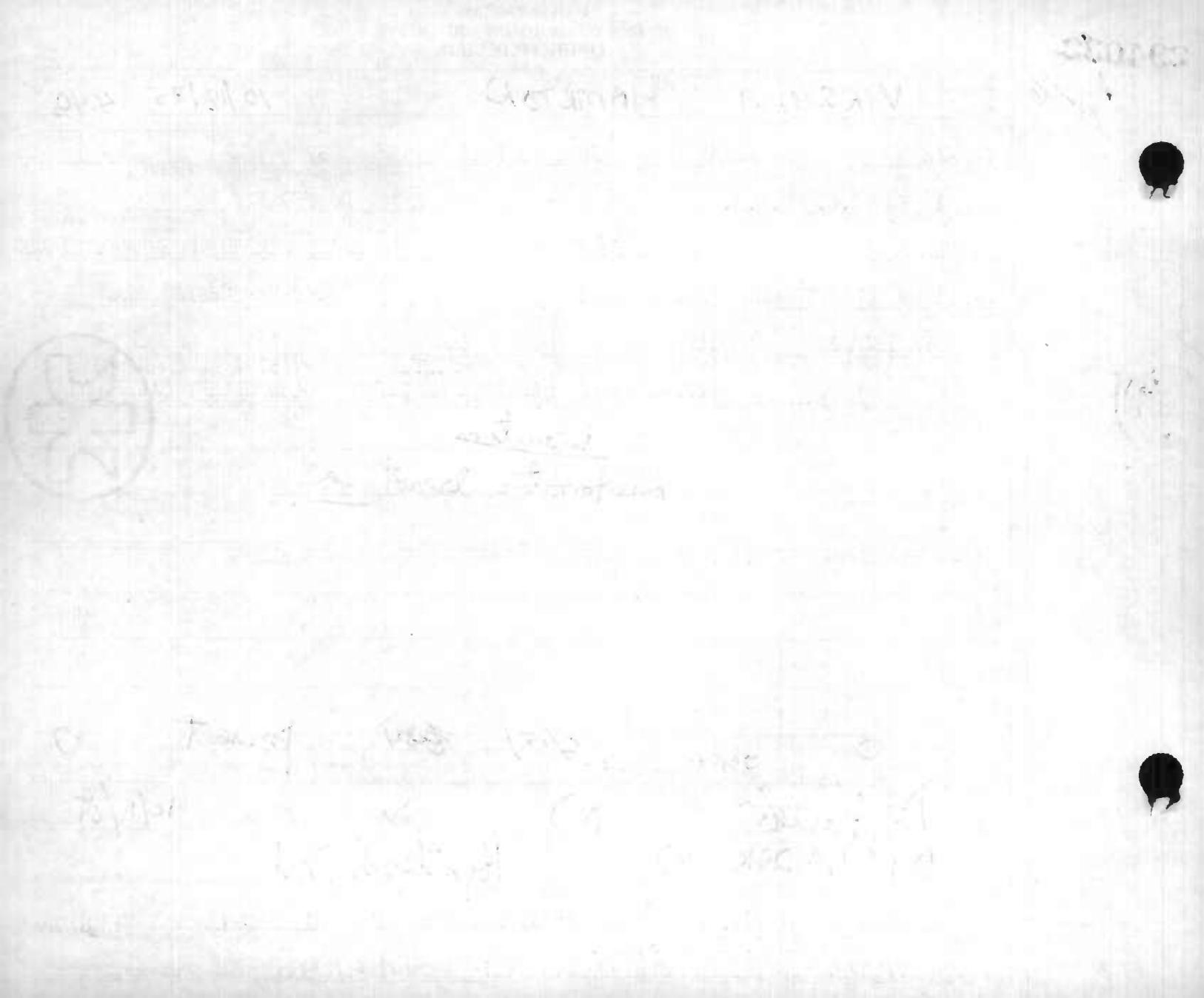
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 29050

REG. NO.

1 - STATE  
REGISTRAR

|   |  |  |  |   |       |   |      |   |  |
|---|--|--|--|---|-------|---|------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST MURRAY LAST  |  | 2a. DATE OF DEATH   | MONTH | DAY   | YEAR | 2b. HOUR  |  |
| VIRGINIA  |  | HAMILTON   |  | 10/14/85  |       |   |      | 4:49 M  |  |
| 3. SEX  |  | 4 RACE   |  | 5. DATE OF BIRTH  |       | 6. AGE (IN YEARS LAST BIRTHDAY)   |      | 7. IF UNDER 1 YEAR<br>MONTHS DAYS   |  |
| FEMALE  |  | CAUCASIAN  |  | JUNE 13, 1928   |       | 57 YRS  |      | IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |       | 9. BALTIMORE CITY OR COUNTY OF DEATH  |      | MD.   |  |
| WASHINGTON, D.C.  |  | U.S.A.   |  |   |       | MONTGOMERY  |      |   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |       | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |      |   |  |
| SILVER SPRING   |  | 8802 MANCHESTER ROAD   |  | SALES PERSON  |       | BRENTANOS BOOKS   |      | 20904   |  |
| 13a. STATE<br>MARYLAND  |  | 13b. COUNTY<br>MONTGOMERY  |  | 13c. CITY OR TOWN<br>SILVER SPRING  |       | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |      | 13e. STREET ADDRESS / ZIP CODE<br>8802 MANCHESTER ROAD  |  |
| 14. FATHER'S NAME<br>STANISLAUS   |  | MIDDLE LAST<br>HAMILTON  |  | 15. MOTHER'S MAIDEN NAME<br>LUCY  |       |   |      | LAST BREWER   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>215-26-0301  |  | 17. INFORMANT SISTER<br>LUCINDA HAMILTON  |       | AD15191 BURBANK DRIVE<br>GLEN ELLEN, CALIFORNIA   |      | 45442   |  |
| <p><b>18. CAUSE OF DEATH:</b> Enter only one cause per line for 1a, 1b, and 1c.</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a): <u>malaria</u></p> <p>DUE TO, OR AS A CONSEQUENCE OF<br/>(b): <u>metastatic breast ca</u></p> <p>DUE TO, OR AS A CONSEQUENCE OF<br/>(c):</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: b</p>   |  |  |  |   |       |   |      |   |  |
| MEDICAL CERTIFICATION   |  | 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |      | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
|   |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I, OR PART II)                |      |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET   |       | CITY OR TOWN  |      | COUNTY STATE  |  |
| <p>22a. I certify that (I) this hospital attended the deceased from <u>Sept 1985</u> to <u>1/15/1986</u>, that (I) last saw the deceased alive on <u>Sept 1985</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.</p> <p>22b. SIGNATURE<br/><u>D.J. Haidak MD</u></p> <p>22c. DEGREE<br/><u>MD</u></p> <p>22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/></p> <p>22e. ADDRESS<br/><u>Hallsville, Md</u></p> <p>22f. DATE SIGNED<br/><u>10/15/85</u></p> |  |  |  |   |       |   |      |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE<br>CREMATION 10/15/85  |  | 23c. NAME OF CEMETERY OR CREMATORIUM<br>METROPOLITAN CREMATORIUM  |       | 23d. LOCATION<br>CITY OR TOWN<br>ALEXANDRIA   |      | COUNTY STATE<br>VIRGINIA  |  |
| 24. FUNERAL DIRECTOR<br>NAME  |  | FRANCIS J. COLLINS, JR.  |  | 25a. DATE REC'D. BY REGISTRAR   |       | 25b. REGISTRAR'S SIGNATURE<br><u>Jeanne Davidson Mandel</u>                                     |      |   |  |
|   |  |  |  | OCT 17 1985   |       |   |      |   |  |
| DHMH - 16 60M 7/84<br>(VRA 15, 4)   |  |  |  |   |       |   |      |   |  |



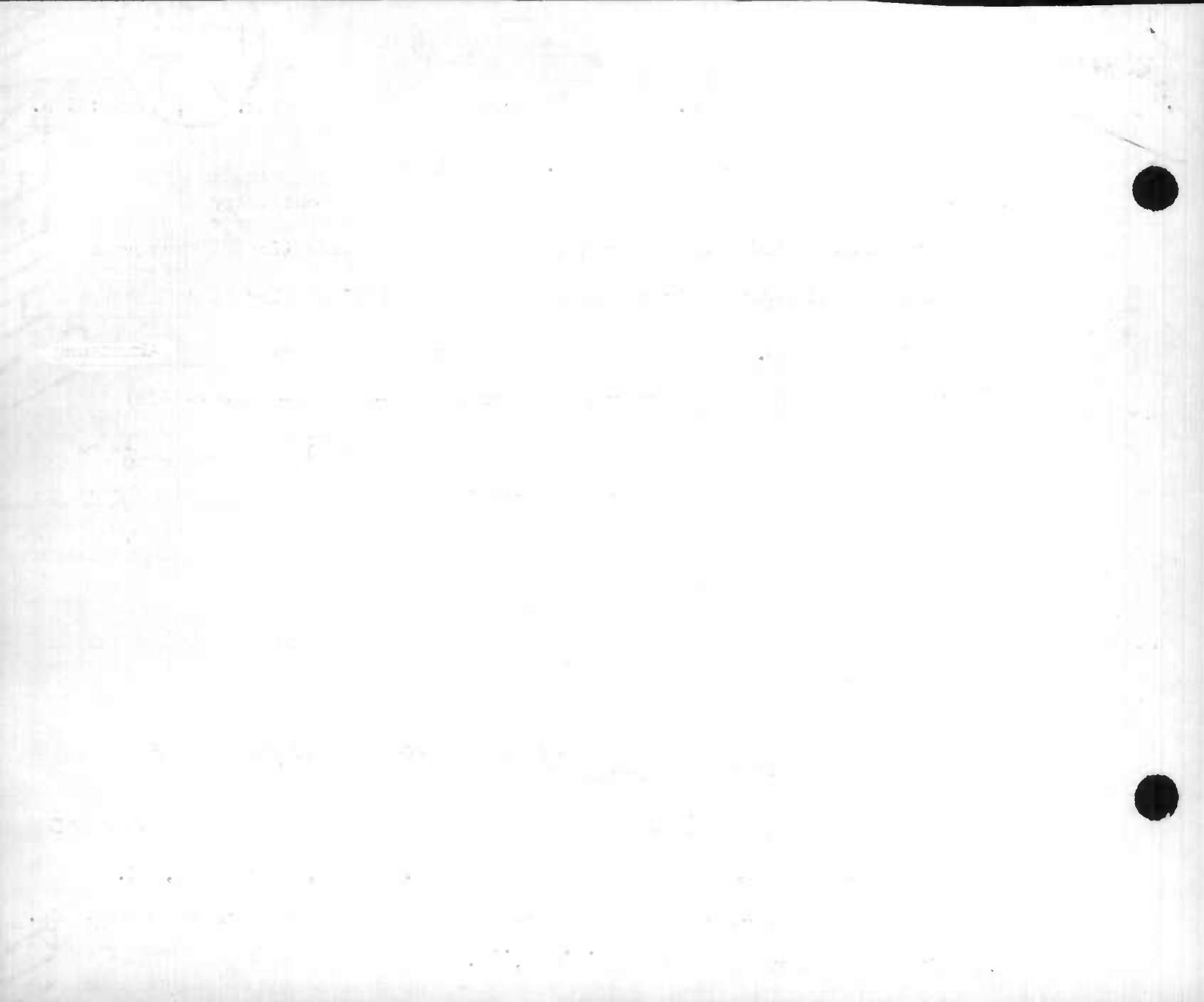
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached from the burial folder sheet. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified before death.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |               |   |   |   |   | REG. NO. 8529051  |                 |   |      |
|---|--|---|--|---|---------------|---|---|---|---|---|-----------------|---|------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   | FIRST<br>Barbara   | MIDDLE<br>A.  | LAST<br>Haney | 2a. DATE OF DEATH<br>MONTH DAY YEAR   |   |   | 2b. HOUR<br>Oct. 11, 1985 8:35 A.M.   |   |                 |   |      |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR  |               |   | 6. AGE (IN YEARS LAST BIRTHDAY)                           |   | IF UNDER 1 YEAR   |   | IF UNDER 24 HRS |   |      |
|   |  |   |  | Aug. 2 1931   |               |   | 54  |   | YEARS   | MONTHS  | DAYS            | HOURS   | MIN. |
| 7a. BIRTHPLACE<br><b>Pennsylvania</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8<br>MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |               |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> |   |   | MD  |                 |   |      |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><b>Holy Cross Hospital</b> |  |   |               |   | 12a. USUAL OCCUPATION<br><b>Housewife</b>                 |   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>own home</b>  |                 |   |      |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |   |               |   |   |   |   | 13. STREET ADDRESS / ZIP CODE<br><b>1515 Ainsley Road 20904</b>   |                 |   |      |
| 14. STATE<br><b>Maryland</b>  |  | 15. COUNTY<br><b>Montgomery</b>   |  | 16. CITY OR TOWN<br><b>Silver Spring</b>  |               | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 14. STREET ADDRESS / ZIP CODE<br><b>1515 Ainsley Road 20904</b> |   |   |                 |   |      |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>N/A</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>N/A</b>                 |  | 16c. SOCIAL SECURITY NO.<br><b>425-58-6710</b>  |               | 17. INFORMANT   |   | ADDRESS<br><b>Warren Haney-husband-(same as 13e)</b>            |   |   |                 |   |      |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1(a), (b) and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)   |  |   |  |   |               |   |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>8 years</b>   |                 |   |      |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Carcinoma of Breast</b>  |  |   |  |   |               |   |   |   |   | 1 year  |                 |   |      |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause last  |  |   |  |   |               |   |   |   |   |   |                 |   |      |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Carcinoma of Breast</b>  |  |   |  |   |               |   |   |   |   |   |                 |   |      |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |  |   |               |   |   |   |   |   |                 |   |      |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                     |   |               | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |                 |   |      |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19           |   |               | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART II)               |   |   |   |   |                 |   |      |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM ETC.) |   |               | 21f. LOCATION<br>STREET   |   |   | CITY OR TOWN  |   | COUNTY          | STATE   |      |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/26 1980</b> to <b>10/11 1985</b> that (I) (we) last<br>saw the deceased alive on <b>10/7 1985</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) did (did not) view the body after death. |  |   |  |   |               |   |   |   |   |   |                 |   |      |
| 22b. SIGNATURE<br><b>Jeremy Cooke</b>   |  |   |  |   |               |   |   |   |   | 22c. DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                 |   |      |
| 22d. DATE SIGNED<br><b>10/11/85</b>   |  |   |  |   |               |   |   |   |   |   |                 |   |      |
| 22e. ADDRESS<br><b>10400 Conn. Avenue, Kensington, Md.</b>  |  |   |  |   |               |   |   |   |   |   |                 |   |      |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |   | 23b. DATE<br><b>10-15-1985</b>                                       |   |               | 23c. NAME OF CEMETERY OR CREMATORIAL<br><b>George Washington</b>                                |   |   | 23d. LOCATION<br>CITY OWN COUNTY<br><b>Adelphi Prince Georges Md.</b>   |   |                 |   |      |
| 24. FUNERAL DIRECTOR<br><b>Hines/Rinaldi Funeral Home Silver Spring, Md.</b>  |  |   |  |   |               |   |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>Oct 15 1985</b>   |                 | 25b. REGISTRAR'S SIGNATURE<br><b>J. Rinaldi</b> |      |
| DHMH - 16 50M 4/83<br>(VRA 15, 4)   |  |   |  |   |               |   |   |   |   |   |                 |   |      |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be reigned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transcript. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |   |   |   |   | REG. NO. 85 29052                   |  |   |                       |       |  |
|---|--|--|--|--|--|---|---|---|---|-------------------------------------|--|---|-----------------------|-------|--|
| 1 - STATE REGISTRAR<br><b>297084</b>  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>Oct. 15, 1985</b>   |  |  |   |   |   |   | 2b. HOUR<br><b>4:00 P.M.</b>        |  |   |                       |       |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Cloey Holladay Hardesty</b>   |  |  | MIDDLE LAST  |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>May 15, 1928</b>                     |   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>57 YRS.</b>  |                                     |  |   |                       |       |  |
| 3 SEX<br><b>female</b>  |  | 4. RACE<br><b>white</b>  |  | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b> |  |   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                     |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery Co</b>      |                       |       |  |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1304 Millgrove Place</b> |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>housewife</b> |   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>household</b> |   |                                     |  |   |                       |       |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Mont.</b>  |  | 13c. CITY OR TOWN<br><b>Silver Spring</b>                    |  |   | 13d. INSIDE CITY LIMITS?<br><input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE<br><b>1304 Millgrove Place 20901</b>   |                                     |  |   |                       |       |  |
| 14. FATHER'S NAME<br>FIRST<br><b>John</b>   |  |  | MIDDLE<br><b>E.</b>  |  | LAST<br><b>Holladay</b>  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST<br><b>Cloey</b>     |   |                                     | MIDDLE<br><b>E.</b>  |   | LAST<br><b>O'Neal</b> |       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>579-32-8701</b>   |  |  | 17. INFORMANT<br><b>Thomas K.C. Hardesty same as 13e.</b>                     |   |   | ADDRESS   |                                     |  |   |                       |       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a)<br><br>Conditions, if any, which<br>gave rise to immediate<br>cause (b), stating the<br>underlying cause last  |  |  |  |  |  |   |   |   |   | <i>Metastatic Cervical Cancer</i>   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>5 years</b> |                       |       |  |
| (b) <i>Adenocarcinoma of Breast</i>   |  |  |  |  |  |   |   |   |   | <b>6 years</b>                      |  |   |                       |       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |  |   |   |   |   |                                     |  |   |                       |       |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |   |   | 20a. AUTOPSY?   |   |                                     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |   |                       |       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |   |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                     |  |   |                       |       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  | 21f. LOCATION<br>STREET   |   |   | CITY OR TOWN  |                                     | COUNTY   |   | STATE                 |       |  |
| 22a. I certify that (I) <input type="checkbox"/> (we) <input type="checkbox"/> attended the deceased from <b>JULY 30 1982</b> to <b>OCTOBER 15, 1985</b> , that (I) <input type="checkbox"/> (we) <input type="checkbox"/> last saw the deceased alive on <b>OCTOBER 11 1985</b> , and that in (my) <input type="checkbox"/> (our) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input type="checkbox"/> (we) <input type="checkbox"/> did not view the body after death. |  |  |  |  |  |   |   |   |   | 22c. DATE SIGNED<br><b>10-15-85</b> |  |   |                       |       |  |
| 22b. SIGNATURE<br><i>Leonard Gold, M.D.</i>   |  |  | 22c. DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  | 22d. ADDRESS<br><b>8630 FENTON ST # 230 Silver Spring MD 20910</b>            |   |   |   |                                     |  |   |                       |       |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>10/18/85</b>   |  |  | 23c. NAME OF CEMETERY OR CREMATORIAL<br><b>Quaker Cemetery</b>                |   |   | 23d. LOCATION CITY OR TOWN<br><b>Galesville, A.A. Co. Md.</b>   |                                     |  | 23e. COUNTY   |                       | STATE |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Hardesty Funeral Home 12 Ridgely Ann.</b>   |  |  | ADDRESS  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 22 1985</b>                           |   |   | 25b. REGISTRAR'S SIGNATURE<br><i>Jane Hardisty</i>  |                                     |  |   |                       |       |  |

28000

298002

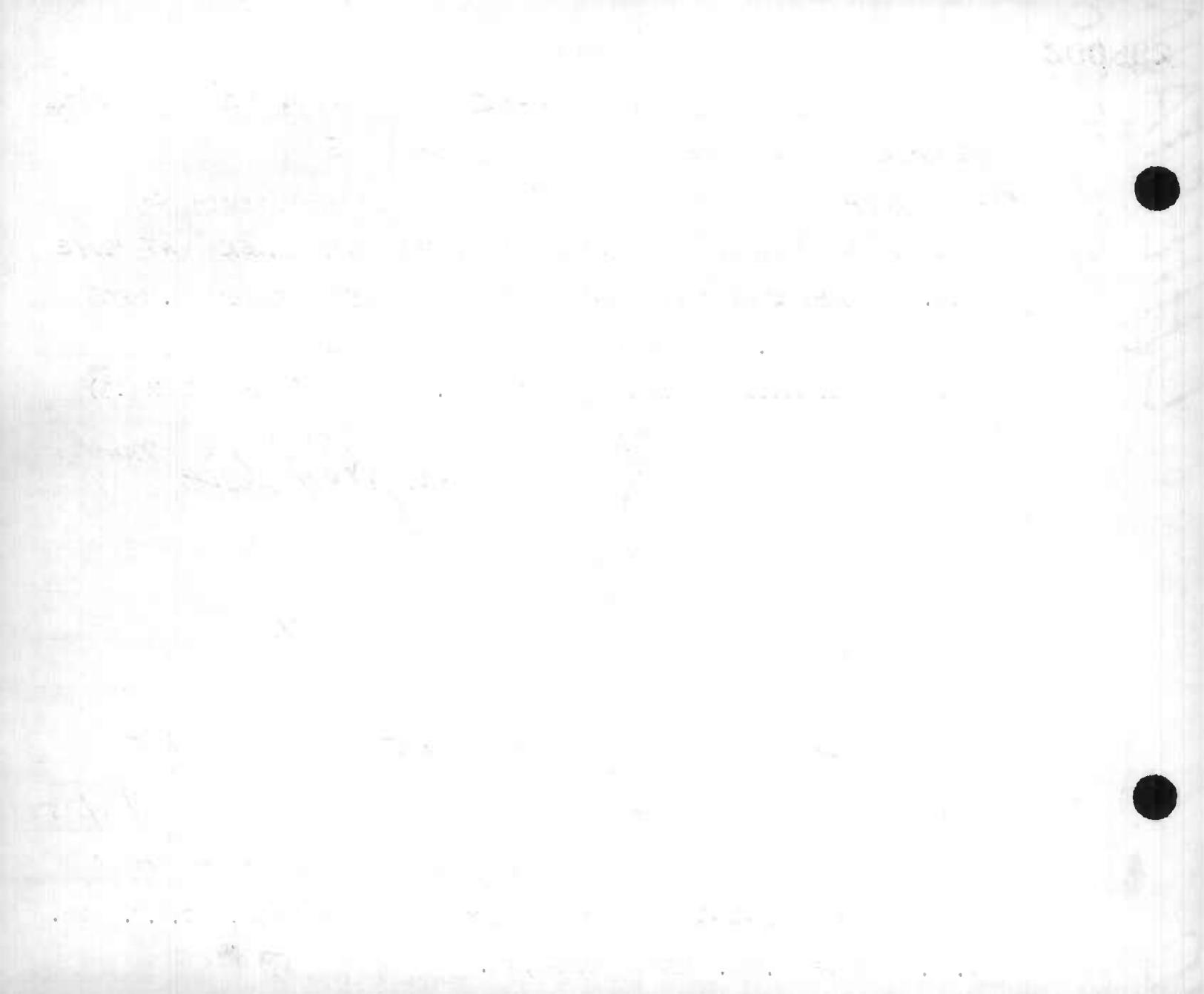
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and countersigned by the funeral director, place 3 should be detached for use on the burial permit. Then please remove carbon paper. Place item 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or if Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |                |   |  |  |   |  | 8 5 29053  |   |       |                 |          |  |  |
|---|--|--|---|----------------|---|--|--|---|--|--|---|-------|-----------------|----------|--|--|
|   |  |  |   |                |   |  |  |   |  | REG. NO.   |   |       |                 |          |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  | FIRST   | MIDDLE         | LAST  |  |  | 2a. DATE OF DEATH   |  |  | MONTH   | DAY   | YEAR            | 2b. HOUR |  |  |
| Inez McCain   |  |  |   |                | HARE  |  |  | 10-14-85  |  |  |   |       |                 | 6:30 AM  |  |  |
| 3. SEX  |  |  | 4. RACE   |                | 5. DATE OF BIRTH  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  |  | IF UNDER 1 YEAR                                 |       | IF UNDER 24 HRS |          |  |  |
| FEMALE  |  |  | WHITE   |                | MONTH 8 DAY 26 YEAR 00  |  |  | 85  |  |  | MONTHS  | YEARS | HOURS           | MIN.     |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |  | 7b. CITIZEN OF WHAT COUNTRY?  |                | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |  | MD.   |       |                 |          |  |  |
| So. DAKOTA  |  |  | USA   |                |   |  |  | Montgomery Co.  |  |  |   |       |                 |          |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                | 12a. USUAL OCCUPATION   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  | WORKING LIFE                                    |       |                 |          |  |  |
| Tokoma Pk.  |  |  | Wash. Adventist Hospital  |                | HOME MAKER  |  |  | AT HOME   |  |  |   |       |                 |          |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |   |                |   |  |  |   |  | 13a. STREET ADDRESS / ZIP CODE                                 |   |       |                 |          |  |  |
| 13e. STATE<br>Md.   |  |  | 13b. COUNTY<br>MONTGOMERY   |                | 13c. CITY OR TOWN<br>SILVER SPRING  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 3310 CHISWICK CT. 20906                         |       |                 |          |  |  |
| 14. FATHER'S NAME<br>FIRST<br>LYNN  |  |  | MIDDLE<br>P.  | LAST<br>McCAIN | 15. MOTHER'S MAIDEN NAME<br>UNKNOWN   |  |  |   |  |  |   |       |                 |          |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   |                | 17. INFORMANT   |  |  | ADDRESS   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |       |                 |          |  |  |
| NO  |  |  | 578-62-4073   |                | ROBERT S. HARE  |  |  | (SAME AS ITEM #13)  |  |  | months  |       |                 |          |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)  |  |  |   |                |   |  |  |   |  | Congestive Heart Failure                                       |   |       |                 |          |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) Atherosclerotic heart disease   |  |  |   |                |   |  |  |   |  |  |   |       |                 |          |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c)   |  |  |   |                |   |  |  |   |  |  |   |       |                 |          |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |   |                |   |  |  |   |  |  |   |       |                 |          |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                |   |  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |   |       |                 |          |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(# EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                             |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |   |       |                 |          |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |                | 21f. LOCATION<br>STREET   |  |  | CITY OR TOWN  |  | COUNTY   | STATE   |       |                 |          |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-2-1985 to 10-14-1985, that (I) (we) last saw the deceased alive on 10-11-1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. |  |  |   |                |   |  |  |   |  | 22c. DATE SIGNED<br>10/15/85                                   |   |       |                 |          |  |  |
| 22b. SIGNATURE<br>Surinder Singh  |  |  | DEGREE  |                |   |  |  |   |  |  |   |       |                 |          |  |  |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT)<br>SURINDER SINGH   |  |  | 22d. ADDRESS 4713 Berrwyn Rd. 1<br>Colleg Park, MD. 20740   |                |   |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/>   |  | MEDICAL DIRECTOR <input type="checkbox"/>                      | STAFF PHYSICIAN <input type="checkbox"/>        |       |                 |          |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>CREMATION   |  |  | 23b. DATE<br>10-16-1985   |                | 23c. NAME OF CEMETERY OR CREMATORIAL<br>CHAMBERS CREMATORY  |  |  | 23d. LOCATION<br>RIVERDALE, P.G.C. Md.  |  |  |   |       |                 |          |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>W. W. CHAMBERS CO. INC.   |  |  | ADDRESS<br>SILVER SPRING, Md.   |                | 25a. DATE REC'D. BY REGISTRAR<br>06123  |  |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Murphy  |  |  |   |       |                 |          |  |  |



305148

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event the medical examiner should be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |             |   |                   |  |  |                                      |  |  |                                   |      |  |  |  |
|---|--|-------------|---|-------------------|--|--|--------------------------------------|--|--|-----------------------------------|------|--|--|--|
| REG. NO. 8 5 2 9 0 3 4  |  |             |   |                   |  |  |                                      |  |  |                                   |      |  |  |  |
| 1. FOR<br>STATE<br>REGISTRAR  |  |             | KATHERINE   |                   |  |  |                                      |  |  |                                   |      |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |             | FIRST   | MIDDLE            | LAST   | 2a. DATE OF DEATH  |                                      |  | MONTH  | DAY                               | YEAR | 2b. HOUR   |  |  |
| KATHERINE L. HARPER   |  |             |   |                   |  | 10/22/85   |                                      |  |  |                                   |      | 4:32 PM  |  |  |
| 3. SEX  |  |             | 4. RACE   |                   | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)      |  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS |      | 8. IF UNDER 24 HRS<br>MONTHS DAYS HOURS MIN                    |  |  |
| FEMALE  |  |             | BLACK   |                   | MAR. 30, 1919  |  | 66                                   |  |  |                                   |      |  |  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)   |  |             | 7b. CITIZEN OF WHAT COUNTRY?  |                   | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |  |                                   |      |  |  |  |
| WASH. DC  |  |             | USA   |                   |  |  | MONTGOMERY                           |  |  |                                   |      |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  |             | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY |  |  |                                   |      |  |  |  |
| BETHESDA  |  |             | SUBURBAN HOSPITAL   |                   | Unemployed   |  |                                      |  |  |                                   |      |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |             |   |                   |  |  |                                      |  |  |                                   |      |  |  |  |
| 13a. STATE  |  | 13b. COUNTY |   | 13c. CITY OR TOWN |  | 13d. INSIDE CITY LIMITS?   |                                      |  | 13e. STREET ADDRESS / ZIP CODE                           |                                   |      |  |  |  |
| MARYLAND  |  | MONTGOMERY  |   | FOTOMAC           |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                      |  | 7802 SCOTLAND DR. / 20854                                |                                   |      |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |  |             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |                   |  |  |                                      |  |  |                                   |      |  |  |  |
| Thomas E. Hart  |  |             | MARY B. HARRIS  |                   |  |  |                                      |  |  |                                   |      |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |             | 16b. SOCIAL SECURITY NO.  |                   |  | 17. INFORMANT  |                                      |  | ADDRESS  |                                   |      |  |  |  |
| No  |  |             | 218-20-0263   |                   |  | Shirley Claggett   |                                      |  | 821 Berkshire Dr.<br>Hyattsville, Md.                    |                                   |      |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY: CARDIORESPIRATORY ARREST<br>IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |             |   |                   |  |  |                                      |  |  |                                   |      |  |  |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF<br>(c) DUE TO, OR AS A CONSEQUENCE OF  |  |             |   |                   |  |  |                                      |  |  |                                   |      |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a<br>Diabetes mellitus; possible coronary artery disease   |  |             |   |                   |  |  |                                      |  |  |                                   |      |  |  |  |
| 19a. MEDICAL CERTIFICATION  |  |             | 19b. DATE OF OPERATION  |                   |  | 19c. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                      |  | 20a. AUTOPSY?  |                                   |      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |
|   |  |             |   |                   |  |  |                                      |  | YES <input type="checkbox"/> NO <input type="checkbox"/> |                                   |      | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |             | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                   |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)   |                                      |  |  |                                   |      |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK   |  |             | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |                   |  | 21f. LOCATION<br>STREET  |                                      |  | CITY OR TOWN   |                                   |      | COUNTY STATE   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from october 22, 1985, to october 22, 1985, that (I) (we) last saw the deceased alive on october 22, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |             |   |                   |  |  |                                      |  |  |                                   |      |  |  |  |
| 22b. SIGNATURE  |  |             | 22c. DEGREE   |                   |  | 22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                      |  | 22e. DATE SIGNED   |                                   |      |  |  |  |
| JA QUIRUS MD  |  |             | PHYSICIAN   |                   |  |  |                                      |  | 10/22/85   |                                   |      |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |             | 22e. ADDRESS  |                   |  | 5490 Wisconsin Av Chevy Chase MD 20815   |                                      |  |  |                                   |      |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  |             | 23b. DATE   |                   |  | 23c. NAME OF CEMETERY OR Crematory   |                                      |  | 23d. LOCATION<br>CITY OR TOWN                            |                                   |      | 23e. COUNTY  |  |  |
| Burial  |  |             | 10-26-85  |                   |  | Md. Nat'l Mem. Pk  |                                      |  | Hager P. Geo Md.   |                                   |      |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME  |  |             | ADDRESS   |                   |  | 25a. DATE REC'D. BY REGISTRAR  |                                      |  | 25b. REGISTRAR'S SIGNATURE                               |                                   |      |  |  |  |
| George R. Snowden   |  |             | Rockville, Md.  |                   |  | OCT 28 1985  |                                      |  | John Darden, Jr.   |                                   |      |  |  |  |

BR1200

(a)



305039

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove from死者, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |  |  |  |  |  |   |  |  | 8529054   |  |
|---|--|--|---|--|--|--|--|--|---|--|--|---|--|
|   |  |  |   |  |  |  |  |  |   |  |  | REG. NO.  |  |
| 1 - STATE REGISTRAR   |  |  | I. DECEASED NAME<br>(TYPE OR PRINT)   |  |  | FIRST MIDDLE LAST  |  |  | 2d. DATE OF DEATH MONTH DAY YEAR                                    |  |  | 2b. HOUR  |  |
| #   |  |  | BETTY   |  |  | Kelly HARTMAN  |  |  | 10/26/85  |  |  | 53 PM   |  |
| 3. SEX  |  |  | 4. RACE   |  |  | 5. DATE OF BIRTH   |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  |  | IF UNDER 1 YEAR                                 |  |
| Female  |  |  | White   |  |  | Oct. 13 <sup>TH</sup> , 1914   |  |  | 71  |  |  | MONTHS DAYS                                     |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)   |  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  |  | 8  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  | IF UNDER 24 HRS                                 |  |
| Washington, D.C.  |  |  | U.S.A.  |  |  | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | Montgomery County   |  |  | MONTHS HOURS MIN.                               |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY                                |  |  |   |  |
| Takoma Park   |  |  | Washington Adventist Hospital   |  |  | Salesperson  |  |  | Department  |  |  |   |  |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  | 14. FATHER'S NAME   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  | 13e. STREET ADDRESS / ZIP CODE                                      |  |  |   |  |
| Maryland  |  |  | FIRST MIDDLE LAST   |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  | 5910 48th Avenue  |  |  |   |  |
| 14. FATHER'S NAME   |  |  | William James Kelly   |  |  | 15. MOTHER'S MAIDEN NAME   |  |  | ADDRESS   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |  | 16b. SOCIAL SECURITY NO.  |  |  | 17. INFORMANT  |  |  | Lester  |  |  |   |  |
| No  |  |  | 578-16-5268   |  |  | Mr. Joseph A. Hartman, Jr. (Son)   |  |  | Same as 13  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  |  |  |   |  |  |  |  |  |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardio Respiratory arrest due to Reversible<br/>Atrial multiple ventricular<br/>Tachycardia</u>  |  |  |   |  |  |  |  |  |   |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>myocardial infarction</u>  |  |  |   |  |  |  |  |  |   |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Advanced chronic obstructive Pulmonary<br/>Disease</u>   |  |  |   |  |  |  |  |  |   |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I   |  |  |   |  |  |  |  |  |   |  |  |   |  |
| ① Borderline Diabetes ② Parkinson Disease ③ Depression ④ Osteoporosis   |  |  |   |  |  |  |  |  |   |  |  |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?  |  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?   |  |  |   |  |
| None  |  |  | None  |  |  | <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)<br>NA  |  |  |   |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  |  | 21f. LOCATION<br>STREET NA CITY OR TOWN COUNTY STATE   |  |  |   |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10-25</u> , 19 <u>85</u> , to <u>10-26</u> , 19 <u>85</u> , that (I) (we) last<br>saw the deceased alive on <u>10-26</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death. |  |  |   |  |  |  |  |  |   |  |  |   |  |
| 22b. SIGNATURE  |  |  | S. Rudrapi MD   |  |  | DEGREE MD  |  |  | 22c. DATE SIGNED  |  |  |   |  |
| ATTENDING<br>PHYSICIAN  |  |  | MEDICAL<br>DIRECTOR   |  |  | STAFF<br>PHYSICIAN   |  |  | 10/26/85  |  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  | SHRINIVAS. R. UDADI   |  |  | 22e. ADDRESS   |  |  | 23d. LOCATION<br>CITY OR TOWN Alexandria COUNTY N/A STATE Virginia  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  |  | 23b. DATE   |  |  | 23c. NAME OF CEMETERY OR CREMATORIAL   |  |  | 23d. LOCATION<br>CITY OR TOWN                                       |  |  |   |  |
| Cremation   |  |  | 10/30/85  |  |  | Metropolitan Crematory   |  |  | Alexandria  |  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME  |  |  | ADDRESS   |  |  | 25a. DATE REC'D. BY REGISTRAR  |  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |   |  |
| Francis Gasch's Sons Funeral Home, P.A.   |  |  |   |  |  | OCT 30 1985  |  |  | John Anderson   |  |  |   |  |
| 4739 Baltimore Avenue Hyattsville, Md. 20781  |  |  |   |  |  |  |  |  |   |  |  |   |  |

031308

2016-01

080073011

X77381

Acoustic communication  
between two individuals  
of different species  
and two individuals  
of the same species.

Communication between  
two individuals of the same species.

Am

Bm

Br

Ac|st

represented by vertical bars

whereas the horizontal bars represent the duration

080073011 0803100

318030

8529056

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |  |                  |                                      |   |  |   |                                |        |                    |      |
|--|--|--|------------------|--------------------------------------|---|--|---|--------------------------------|--------|--------------------|------|
| 1. DECEASED NAME   |  |  | FIRST            | MIDDLE                               | LAST  | 2a. DATE OF DEATH  | MONTH   | DAY                            | YEAR   | 2b. HOUR           |      |
|  |  |  | Marie            | C.                                   | Helzer  | 10-27-85   |   |                                |        | 5:43am             |      |
| 3. SEX   |  | 4. RACE  | 5. DATE OF BIRTH |                                      |   | 6. AGE (IN YEARS LAST BIRTHDAY)  |   | 7. IF UNDER 1 YEAR             |        | 8. IF UNDER 24 HRS |      |
| female   |  | white  | Feb. 20, 1904    |                                      |   | 81   | YRS   | MONTHS                         | DAYS   | HOURS              | MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |                  |                                      | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |                                |        |                    |      |
| Nebraska   |  | U.S.A.   |                  |                                      |   |  | Montgomery County MD.   |                                |        |                    |      |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                  |                                      | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |                                |        |                    |      |
| Rockville  |  | National Lutheran Home   |                  |                                      | clerk   |  | unknown   |                                |        |                    |      |
| 13a. STATE   |  | 13b. COUNTY  |                  | 13c. CITY OR TOWN                    |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE |        | 99999              |      |
| D.C.   |  | ---  |                  | Washington                           |   |  |   | 1811 Irving St. N.E.           |        |                    |      |
| 14. FATHER'S NAME  |  | FIRST  | MIDDLE           | LAST                                 | 15. MOTHER'S MAIDEN NAME  |  | 16. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |                                |        |                    |      |
| Conrad   |  |  |                  | Helzer                               | Anna Katherine Rohrig   |  | 6 mos.  |                                |        |                    |      |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  |  | 16b. SOCIAL SECURITY NO  |                  |                                      | 17. INFORMANT   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) |                                |        |                    |      |
| no   |  | 506-18-6080  |                  |                                      | Rev. Richard Reichard   |  | Renal Failure   |                                |        |                    |      |
| 18c. DUE TO, OR AS A CONSEQUENCE OF (b)  |  | 18d. DUE TO, OR AS A CONSEQUENCE OF (c)  |                  |                                      | 18e. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |   |                                |        |                    |      |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |  |  |                  |                                      | 2 yrs.  |  |   |                                |        |                    |      |
| 18f. DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |                  |                                      |   |  |   |                                |        |                    |      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a   |  |  |                  |                                      |   |  |   |                                |        |                    |      |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                  |                                      | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?  |                                |        |                    |      |
|  |  |  |                  |                                      | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                |        |                    |      |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |                  |                                      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |                                |        |                    |      |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                 |                  |                                      | 21f. LOCATION<br>STREET   |  | CITY OR TOWN  |                                | COUNTY | STATE              |      |
| 22a. I certify that (I) (the hospital) attended the deceased from Aug. 9, 1967, to Oct. 27, 1985, that (I) (we) last saw the deceased alive on Oct. 26, 1985, and that in (my) (our) opinion death occurred on the date and hour and I am the causes stated above. (I) (we) did not view the body after death. |  |  |                  |                                      |   |  |   |                                |        |                    |      |
| 22b. SIGNATURE   |  | 22c. DEGREE  |                  |                                      | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                     |  | 22e. DATE SIGNED  |                                |        |                    |      |
| Harold F.M. McCann, M.D.   |  |  |                  |                                      |   |  | 10-27-85  |                                |        |                    |      |
| 22f. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22g. ADDRESS   |                  |                                      |   |  |   |                                |        |                    |      |
| Harold F.M. McCann, M.D.   |  | 3355-16th St. N.W. Washington, D.C. 20010  |                  |                                      |   |  |   |                                |        |                    |      |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |                  | 23c. NAME OF CEMETERY OR CREMATORIAL |   | 23d. LOCATION<br>CITY OR TOWN  |   | 23e. COUNTY                    |        | 23f. STATE         |      |
| Burial   |  | Oct. 31, 1985  |                  | Ft. Lincoln Cem.                     |   | Bladensburg, Md.   |   |                                |        |                    |      |
| 24. FUNERAL DIRECTOR<br>NAME   |  | ADDRESS  |                  |                                      | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |                                |        |                    |      |
| Hysong Co., Inc.   |  | 1300 N St. N.W. Wash. D.C.   |                  |                                      | NOV 12 1985   |  | Julia Davidson Pendleton  |                                |        |                    |      |

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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 3 should be detached for use as the burial/transit permit. Then please remove carbon copy papers. Page 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other significant event, the medical examiner should be notified.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - STATE REGISTRAR

|  |  |   |       |   |      |  |                 |   |                             |              |             |
|--|--|---|-------|---|------|--|-----------------|---|-----------------------------|--------------|-------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   | FIRST | MIDDLE  | LAST | 20. DATE OF DEATH  | MONTH           | DAY   | YEAR                        | 2b. HOUR     |             |
| <i>Frank R. Hepler</i>   |  |   |       |   |      | <b>October</b>   | <b>25, 1985</b> |   |                             | <b>2:20</b>  |             |
| 3. SEX   |  | 4. RACE   |       | 5. DATE OF BIRTH<br>MONTH DAY YEAR  |      | 6. AGE (IN YEARS LAST BIRTHDAY)  | IF UNDER 1 YEAR |   | 2b. HOUR<br>IF UNDER 24 HRS |              |             |
| <b>Male</b>  |  | <b>White</b>  |       | <b>Aug. 15, 1896</b>  |      | <b>89</b>  | <b>YRS</b>      | <b>MONTHS</b>   | <b>DAYS</b>                 | <b>HOURS</b> | <b>MIN.</b> |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |       | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b>                            |                 |   |                             |              |             |
| 10. CITY OR TOWN OF DEATH<br><b>Rockville</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Collingswood Nursing Home</b> |       | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Boiler Maker</b>   |      |  |                 |   |                             |              |             |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>Montgomery</b>  |       | 13c. CITY OR TOWN<br><b>Potomac</b>   |      | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                 | 13e. STREET ADDRESS / ZIP CODE<br><b>10116 Iron Gate Rd./20854</b>  |                             |              |             |
| 14. FATHER'S NAME<br>FIRST<br><b>Unknown</b>   |  | MIDDLE  |       | LAST  |      | 15. MOTHER'S MAIDEN NAME<br>FIRST<br><b>Unknown</b>                                  |                 | MIDDLE<br>LAST  |                             |              |             |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES OR NO UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>224-01-8854</b>  |       | 17. INFORMANT<br><b>Anna Belle Riley, Same address as #13</b>   |      | ADDRESS  |                 |   |                             |              |             |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)   |  | <i>Congestive Heart Failure</i>   |       |   |      |  |                 | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>1 yr</b>  |                             |              |             |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  | DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>A2o Tenia</i>  |       |   |      |  |                 | 8 mo.   |                             |              |             |
|  |  | DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>Renal Failure</i>  |       |   |      |  |                 | 8 mo.   |                             |              |             |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |       |   |      |  |                 |   |                             |              |             |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |       |   |      | 20a. AUTOPSY?  |                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                             |              |             |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |      |  |                 |   |                             |              |             |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |       | 21f. LOCATION<br>STREET   |      | CITY OR TOWN   |                 | COUNTY  |                             | STATE        |             |
| 22a. I certify that (I) <input type="checkbox"/> (the hospital) attended the deceased from <b>10-15</b> , 19 <b>84</b> , to <b>12-25</b> , 19 <b>85</b> , that (I) <input type="checkbox"/> last saw the deceased alive on <b>10-15</b> , 19 <b>84</b> and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (did) (did not) view the body after death. |  |   |       |   |      |  |                 |   |                             |              |             |
| 22b. SIGNATURE<br><i>William F. Luckett</i>  |  | DEGREE<br><b>MD</b>   |       | ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                                     |      | 22c. DATE SIGNED<br><b>10-25-85</b>  |                 |   |                             |              |             |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>William F. Luckett, M.D.</b>   |  | 22e. ADDRESS<br><b>5000 Reno Road N.W., Washington, D.C.</b>  |       |   |      |  |                 |   |                             |              |             |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>10/28/85</b>  |       | 23c. NAME OF CEMETERY OR CREMATORIAL<br><b>Cedar Hill Cemetery</b>  |      | 23d. LOCATION<br>CITY OR TOWN<br><b>Covington</b> , COUNTY<br><b>Virginia</b>        |                 | 23e. STATE  |                             |              |             |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Joseph Gawler's Sons, Inc.</b>  |  | ADDRESS<br><b>5130 Wisconsin Ave, NW, Washington, D.C. 20016</b>  |       | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 31 1985</b>   |      | 25b. REGISTRAR'S SIGNATURE<br><i>John K. Miller</i>                                  |                 |   |                             |              |             |

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT If item 21 is marked or item 18 shows any injury, or other traumatic event

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

|  |  |   |        |  |                          |  |       |   |                 |                                      |  |
|--|--|---|--------|--|--------------------------|--|-------|---|-----------------|--------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   | FIRST  | MIDDLE   | LAST                     | 2a DATE OF DEATH   | MONTH | DAY   | YEAR            | 2b HOUR                              |  |
|  |  |   | Sandra | F.   | Hexter                   | 10   | 4     | 85  |                 | 7:03 PM                              |  |
| 3. SEX   |  | 4. RACE   |        | 5. DATE OF BIRTH   |                          | 6. AGE (IN YEARS LAST BIRTHDAY)  |       | IF UNDER 1 YEAR   |                 |                                      |  |
| Female   |  | White   |        | MONTH  | DAY                      | YEAR   | 15    | YRS   | IF UNDER 24 HRS |                                      |  |
| 7a BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)   |  | 7b CITIZEN OF WHAT COUNTRY?   |        | 8  |                          | MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |       | 9 BALTIMORE CITY OR COUNTY OF DEATH   |                 |                                      |  |
| Maryland   |  | USA   |        | 4 27 1970  |                          |  |       | Montgomery MD.  |                 |                                      |  |
| 10 CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |        |  |                          | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |       |   |                 | 12b. KIND OF BUSINESS OR<br>INDUSTRY |  |
| Potomac  |  | 10200 Bent Cross DR.  |        |  |                          | Student  |       |   |                 | 20854                                |  |
| 13a. STATE   |  | 13b. COUNTY   |        | 13c. CITY OR TOWN  |                          | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |       | 13e. STREET ADDRESS / ZIP CODE  |                 | 10200 Bent Cross Dr.                 |  |
| Maryland   |  | Montgomery  |        | Potomac  |                          | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |       | 20854   |                 |                                      |  |
| 14. FATHER'S NAME  |  | FIRST   | MIDDLE | LAST   | 15. MOTHER'S MAIDEN NAME |  | FIRST | MIDDLE  | LAST            |                                      |  |
|  |  | Paul  | L      | Hexter Jr.   |                          |  | Linda |   | Jett            |                                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.  |        | 17. INFORMANT  |                          | ADDRESS  |       |   |                 |                                      |  |
| NO   |  | 215-66-6030   |        | Paul L. Hexter Jr.   |                          | Same as 13a/e  |       |   |                 |                                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c.)<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a)   |  |   |        |  |                          |  |       |   |                 |                                      |  |
| Conditions, if any, which gave rise to immediate cause 18a, stating the underlying cause last.   |  |   |        |  |                          |  |       |   |                 |                                      |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) Ebstein's Malformation or Tricuspid Valve 15 yrs   |  |   |        |  |                          |  |       |   |                 |                                      |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) congenital heart disease 15 yrs  |  |   |        |  |                          |  |       |   |                 |                                      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 18a<br>none  |  |   |        |  |                          |  |       |   |                 |                                      |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |        |  |                          | 20a. AUTOPSY?  |       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                 |                                      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                          |  |       |   |                 |                                      |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |        | 21f. LOCATION<br>STREET  |                          | CITY OR TOWN   |       | COUNTY  | STATE           |                                      |  |
| 22a. I certify that (I) (this hospital) attended the deceased from April 9, 1985, to October 4, 1985, that (I) (we) last saw the deceased alive on October 3, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |        |  |                          |  |       |   |                 |                                      |  |
| 22b. SIGNATURE   |  | DEGREE  |        |  |                          | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |       |   |                 | 22c. DATE SIGNED                     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   |        |  |                          | 111 Michigan Ave, NW<br>Washington D.C. 20010  |       |   |                 | 10/4/85                              |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(IF APPLICABLE)   |  | 23b. DATE   |        | 23c. NAME OF CEMETERY OR CREMATORIAL<br>LOCATION                               |                          |  |       |   |                 |                                      |  |
| Burial   |  | 10-7-85   |        | Sunset M.P. Berlin, MD 21811   |                          |  |       |   |                 |                                      |  |
| 24. FUNERAL DIRECTOR<br>NAME   |  | ADDRESS   |        |  |                          | 25a. DATE REC'D. BY REGISTRAR  |       | 25b. REGISTRAR'S SIGNATURE  |                 |                                      |  |
| ULLRICH F.H. BERLIN, MD.   |  |   |        |  |                          | OCT 9 1985   |       | Julia Davidson Pendle   |                 |                                      |  |

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician, it should be detached for use as the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18a has any injury, or other traumatic event, the medical examiner must be notified.

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NO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be attached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached from the burial/transit panel. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours after death.

FROM THE STATE DEPT. OF HEALTH AND MENTAL HYGIENE: If item 21 is marked or item 18 the only injury, or other traumatic event, the medical examiner may file this panel.

## MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

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|   |  |   |                        |  |  |   |                                     |
|---|--|---|------------------------|--|--|---|-------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   | FIRST<br><b>Jessie</b> | MIDDLE<br><b>M.</b>  | LAST<br><b>Hill</b>  | 2a. DATE OF DEATH<br>MONTH DAY YEAR   | 2b. HOUR                            |
|   |  |   |                        |  | October 6, 1985  | 6:50 AM   |                                     |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec. 17 1905</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>79 YRS   |                                     |
|   |  |   |                        |  |  | IF UNDER 1 YEAR<br>MONTHS    DAYS   | IF UNDER 24 HRS<br>HOURS    MIN     |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Wash., D.C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                        | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery, MD.</b>  |                                     |
| 10. CITY OR TOWN OF DEATH<br><b>Rockville</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Potomac Valley Nursing Home</b> |                        | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Sect.</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Railroad</b>  |                                     |
| 13a. STATE<br><b>none</b>   |  | 13b. COUNTY<br><b>none</b>  |                        | 13c. CITY OR TOWN<br><b>Wash., D.C.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               |                                     |
| 14. FATHER'S NAME<br>FIRST<br><b>Dennis F.</b>  |  | MIDDLE<br><b>McCarthy</b>   |                        | LAST   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST<br><b>Rita</b>  |                                     |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>no</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>722-16-8795</b>   |                        | 17. INFORMANT<br><b>Teresa A. Moroney (niece)</b>  |  | ADDRESS<br><b>19314 ElderBerry Germantown, Md.</b>  |                                     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>BREAST CANCER</b><br>APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>13 YEARS</b>  |  |   |                        |  |  |   |                                     |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |   |                        |  |  |   |                                     |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a  |  |   |                        |  |  |   |                                     |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                        |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                     |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |                                     |
| 21d. INJURY OCCURRED<br>WHITE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/><br>AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                        | 21f. LOCATION<br>STREET  |  | CITY OR TOWN  | COUNTY STATE                        |
| 22a. I certify that (I) <input type="checkbox"/> attended the deceased from <b>25 SEPT 1985</b> , to <b>19 84</b> , to <b>6 OCT 19 85</b> , and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> did (did not) view the body after death. |  |   |                        |  |  |   |                                     |
| 22b. SIGNATURE<br><i>Walter E. Gooch, M.D.</i>  |  | DEGREE  |                        | ATTENDING PHYSICIAN <input checked="" type="checkbox"/>  | MEDICAL DIRECTOR <input type="checkbox"/>  | STAFF PHYSICIAN <input type="checkbox"/>  | 22c. DATE SIGNED<br><b>7 OCT 85</b> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Walter E. Gooch, M.D.</b>   |  | 22e. ADDRESS<br><b>2309 Shorefield Rd., Wheaton, Md.</b>  |                        |  |  |   |                                     |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>Oct. 8 '85</b>  |                        | 23c. NAME OF CEMETERY OR CREMATORIAL<br><b>Mt. Olivet Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN<br><b>Washington, D.C.</b>  |                                     |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>LeVol Funeral Home</i>   |  | ADDRESS<br><b>Washington, D.C.</b>  |                        | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 10 1985</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Julia Neidra Pendleton</i>   |                                     |

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3. II. Letter to Vol.  
C. G. Schaeffer

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

852906

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FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |                                      |          |   |  |   |                                |            |                 |   |
|--|--|---|--------------------------------------|----------|---|--|---|--------------------------------|------------|-----------------|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   | FIRST                                | MIDDLE   | LAST  | 7a. DATE OF DEATH                      | MONTH   | DAY                            | YEAR       | 7b. HOUR        |   |
| Marjorie F. Hoagland   |  |   |                                      |          |   | 10                                     | 30  | 85                             | 7.40 A.M.  |                 |   |
| 3. SEX   |  | 4. RACE   | 5. DATE OF BIRTH                     |          |   | 6. AGE (IN YEARS LAST BIRTHDAY)        |   | IF UNDER 1 YEAR                |            | IF UNDER 24 HRS |   |
| Female   |  | Caucasian   | November 24, 1911                    |          |   | 73                                     | YRS   |                                |            |                 |   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |                                      |          | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |                                |            |                 |   |
| Kentucky   |  | United States   |                                      |          |   |  | Montgomery County, MD.  |                                |            |                 |   |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                      |          | 12a. USUAL OCCUPATION<br>(WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |                                |            |                 |   |
| Bethesda   |  | Suburban Hospital   |                                      |          | Information Specialist  |  | U.S. Gov't.   |                                |            |                 |   |
| 13a. STATE   |  | 13b. COUNTY   | 13c. CITY OR TOWN                    |          |   | 13d. INSIDE CITY LIMITS?               |   | 13e. STREET ADDRESS / ZIP CODE |            |                 |   |
| Maryland   |  | Montgomery  | Bethesda                             |          |   | YES <input type="checkbox"/>           | NO <input checked="" type="checkbox"/>  | 4853 Cordell Ave. #221 20814   |            |                 |   |
| 14. FATHER'S NAME  |  | FIRST   | MIDDLE                               | LAST     | 15. MOTHER'S MAIDEN NAME  |  | FIRST   | MIDDLE                         | LAST       |                 |   |
| Roy  |  |   |                                      | Hoagland | Juliet  |  |   |                                | Foree      |                 |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.  |                                      |          | 17. INFORMANT   |  | 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) |                                |            |                 | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| No   |  | 355 18 0373   |                                      |          | Cousin  |  | 701 Highland Ave. 41008<br>Carrollton, Kentucky   |                                |            |                 |   |
| Mary Masterson   |  |   |                                      |          |   |  |   |                                |            |                 |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <i>Cardio respiratory arrest.</i>  |  |   |                                      |          |   |  |   |                                |            |                 |   |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Coronary artery sclerosis.</i>  |  |   |                                      |          |   |  |   |                                |            |                 |   |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>Arteriosclerosis.</i>   |  |   |                                      |          |   |  |   |                                |            |                 |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a   |  |   |                                      |          |   |  |   |                                |            |                 |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                      |          | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?  |                                |            |                 |   |
|  |  |   |                                      |          | YES <input type="checkbox"/>  | NO <input checked="" type="checkbox"/> | YES <input type="checkbox"/>  |                                |            |                 | NO <input type="checkbox"/>                     |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                                      |          | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |                                |            |                 |   |
| 21d. INJURY OCCURRED<br><br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |                                      |          | 21f. LOCATION<br>STREET   |  | CITY OR TOWN  | COUNTY                         | STATE      |                 |   |
| 22a. I certify that (I) (his hospital) attended the deceased from <i>Sept. 1, 1978</i> to <i>Oct. 30, 1985</i> , that (I) (—) lost<br>soul the deceased alive on <i>October 10, 1985</i> , and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated<br>above, (I) (—) did (I) (—) not view the body after death. |  |   |                                      |          |   |  |   |                                |            |                 |   |
| 22b. SIGNATURE   |  |   |                                      |          | DEGREE  |  | 22c. DATE SIGNED  |                                |            |                 |   |
| <i>John Taber</i>  |  |   |                                      |          | <i>MD</i>   |  | 10-30-85  |                                |            |                 |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS  |                                      |          |   |  |   |                                |            |                 |   |
| <i>John Taber</i>  |  | <i>8218 Wisconsin Ave.</i>  |                                      |          |   |  |   |                                |            |                 |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 23b. DATE   | 23c. NAME OF CEMETERY OR CREMATORIUM |          |   | 23d. LOCATION<br>CITY OR TOWN          |   | 23e. COUNTY                    | 23f. STATE |                 |   |
| Burial   |  | Nov. 6, 1985  | Gate of Heaven Cemetery              |          |   | Mt. Pleasant                           |   |                                | New York   |                 |   |
| 24. FUNERAL DIRECTOR<br>NAME   |  | 25a. ADDRESS  |                                      |          | 25b. DATE REC'D. BY REGISTRAR   |  | 25c. REGISTRAR'S SIGNATURE  |                                |            |                 |   |
| Robert A. Pumphrey, Funeral Homes,<br>P.A., 7557 Wisconsin Ave., Bethesda, Maryland  |  |   |                                      |          | NOV. 05 1985  |  | <i>John Taber</i>   |                                |            |                 |   |
| 20814  |  |   |                                      |          |   |  |   |                                |            |                 |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician it should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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Family history Book

Written by

John Smith

Written on

308037

85 29061

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR.

|  |  |  |   |                       |  |  |                    |  |   |                                      |
|--|--|--|---|-----------------------|--|--|--------------------|--|---|--------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  | FIRST<br><i>Elbert</i>  | MIDDLE<br><i>V.</i>   | LAST<br><i>Holden</i>  | 2a. DATE OF DEATH<br>MONTH<br><i>4</i>   | MONTH<br><i>28</i> | DAY<br><i>25</i>   | YEAR<br><i>10 29 85</i>                             | 2b. HOUR<br><i>8<sup>23</sup>/PM</i> |
| 3. SEX<br><i>Male</i>  |  |  | 4. RACE<br><i>white</i>   |                       | 5. DATE OF BIRTH<br>MONTH<br><i>4</i>  | DAY<br><i>28</i>   | YEAR<br><i>25</i>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>IF UNDER 1 YEAR<br>MONTHS<br><i>60</i>  | IF UNDER 24 HRS.<br>MONTHS<br>DAYS<br>HOURS<br>MIN. |                                      |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><i>N.C.</i>  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |                       | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                    | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Montgomery</i>  |   |                                      |
| 10. CITY OR TOWN OF DEATH<br><i>Silver Spring</i>  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Holy Cross Hosp</i> |                       | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Contractor-Self Employed</i>  |  |                    | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>MD.</i>  |   |                                      |
| 13a. STATE<br><i>MD</i>  |  |  | 13c. CITY OR TOWN<br><i>Montgomery Silver Spring</i>  |                       | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |                    | 13e. STREET ADDRESS / ZIP CODE<br><i>13835 Castle Blvd #2 20904</i>  |   |                                      |
| 14. FATHER'S NAME<br>FIRST<br><i>Henry</i>   |  |  | MIDDLE<br><i>Vance</i>  | LAST<br><i>Holden</i> | 15. MOTHER'S MAIDEN NAME<br>FIRST<br><i>Willar</i>   |  |                    | MIDDLE<br><i></i>  | LAST<br><i>Wilson</i>                               |                                      |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>None</i>  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><i>243 20 9749</i>   |                       | 16c. INFORMANT<br>ADDRESS<br><i>Danvers Court Rockville, Md.</i>   |  |                    | 16d. APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><i>1d</i>  |   |                                      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)  |  |  | DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Lung Cancer</i>  |                       |  |  |                    | 2 yrs  |   |                                      |
|  |  |  | DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i></i>   |                       |  |  |                    |  |   |                                      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><i>Bone mets</i>   |  |  |   |                       |  |  |                    |  |   |                                      |
| 19a. DATE OF OPERATION<br><i>6/83</i>  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>Lung CA</i>  |                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                    | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |                                      |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <i>19</i>   |                       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |                    |  |   |                                      |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                       | 21f. LOCATION<br>STREET<br><i></i>   |  |                    | CITY OR TOWN<br><i></i>  | COUNTY<br><i></i>                                   | STATE<br><i></i>                     |
| 22a. I certify that (I) this hospital attended the deceased from<br>saw the deceased alive on <i>10/18</i> 19 <i>75</i> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (We) (I) did (did not) view the body after death. |  |  |   |                       |  |  |                    |  |   |                                      |
| 22b. SIGNATURE<br><i>Peter Sherer</i>  |  |  | DEGREE<br><i>MP</i>   |                       | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  |                    | 22c. DATE SIGNED<br><i>10/30/85</i>  |   |                                      |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Peter Sherer MD</i>  |  |  | 22e. ADDRESS<br><i>3947 Ferrara Dr. Wheaton MD</i>  |                       |  |  |                    |  |   |                                      |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>  |  |  | 23b. DATE<br><i>11/1/85</i>   |                       | 23c. NAME OF CEMETERY OR CREMATORIAL<br><i>George Washington</i>   |  |                    | 23d. LOCATION<br>CITY OR TOWN<br><i>Adelphi</i>  |   |                                      |
| 24. FUNERAL DIRECTOR<br><i>Hines/Rinaldi 11800 New Hamp.Ave.S.S.Md.</i>  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><i>OCT 31 1985</i>   |                       | 25b. REGISTRAR'S SIGNATURE<br><i>John Wilson</i>   |  |                    |  |   |                                      |

TO HOSPITAL OR ATTENDING PHYSICIAN:  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it may be forwarded to the funeral director. Page 3 should be detached for use as the burial/cremation permit. This certificate may also be used as a medical certificate of death.

IMPORTANT: If Item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed and filed by the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and filed, it may be used on the burial permit. Then please remove carbon copy of this certificate from the death certificate and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

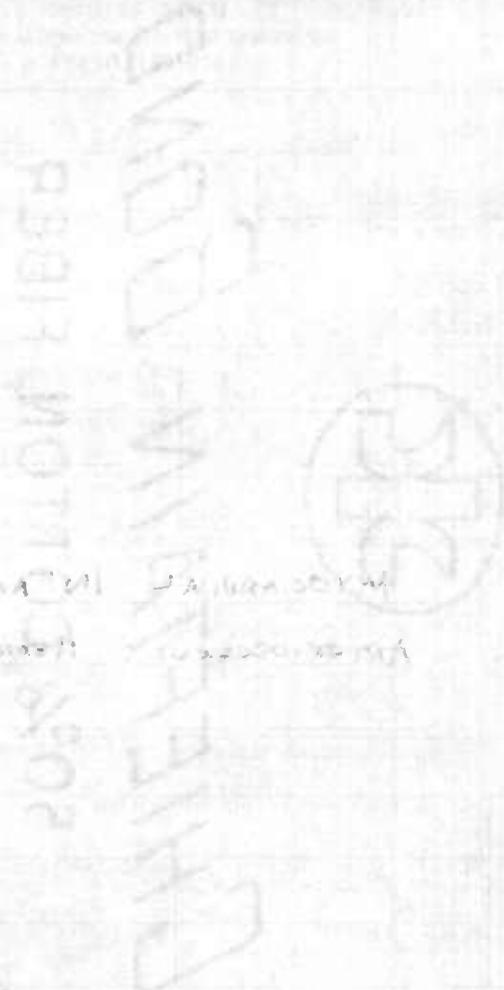
IMPORTANT: If Item 21 is marked as "No" then any injury or other trauma must be medical evidence ruled out.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |   |   |  |  |   |                                     |       |
|---|--|--|--|--|---|---|--|--|---|-------------------------------------|-------|
| 1 - STATE REGISTRAR   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |   |   |  |  | 2b. HOUR  |                                     |       |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Catherine M. Horan</b>  |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec. 14, 1909</b>   |  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75 YRS</b>  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |   |                                     |       |
| 3. SEX<br><b>Female</b>   |  |  | 4. RACE<br><b>Caucasian</b>  |  |   | 7. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |  | 8. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County MD.</b>   |   |                                     |       |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Iowa</b>  |  |  | 7b. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>4411 Highland Avenue</b> |   |                                     |       |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>   |  |  | 13b. COUNTY<br><b>Montgomery</b>   |  |   | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13d. STREET ADDRESS / ZIP CODE<br><b>4411 Highland Avenue/20814</b>  |   |                                     |       |
| 14. FATHER'S NAME<br>FIRST<br><b>James</b>  |  |  | MIDDLE<br><b>McCune</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST<br><b>Catherine</b>   |  | MIDDLE<br>LAST<br><b>Costello</b>  |   |                                     |       |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES OR NO UNKNOWN)<br><b>No</b>  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>220-32-5809</b>  |  |   | 17. INFORMANT<br><b>C.Terrence Horan, same as #13</b>   |  | ADDRESS  |   |                                     |       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>18 HOURS</b>  |  |  |  |  |   |   |  |  |   |                                     |       |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ARTERIOSCLEROTIC HEART DISEASE</b><br>10 YEARS   |  |  |  |  |   |   |  |  |   |                                     |       |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c)   |  |  |  |  |   |   |  |  |   |                                     |       |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |   |   |  |  |   |                                     |       |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  |   |   | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                     |       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I OR PART 2)  |   |  |  |   |                                     |       |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f. LOCATION<br>STREET   |   | CITY OR TOWN   |  |   | COUNTY                              | STATE |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Sept - 1985</b> , to <b>10/13</b> , 19 <b>85</b> , that (we) last saw the deceased alive on <b>Sept - 1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. We did (did not) view the body after death. |  |  |  |  |   |   |  |  |   | 22c. DATE SIGNED<br><b>10/13/85</b> |       |
| 22b. SIGNATURE<br><b>Ralph M. Coan</b>  |  | 22c. DEGREE<br><b>M.D.</b>   |  |  | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22e. ADDRESS<br><b>4400 East West Highway Bethesda, Maryland 20814</b> |  |   |                                     |       |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>Oct. 15, 1985</b>                                      |  | 23c. NAME OF CEMETERY OR CREMATORIAL<br><b>St. Mary's Cemetery</b> |   |   | 23d. LOCATION<br>CITY OR TOWN<br><b>Rockville, Maryland</b>            |  | COUNTY  | STATE                               |       |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland 20814</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 16 1985</b>                    |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>        |   |   |  |  |   |                                     |       |

060109



2010-01

2010-01

2010-01

2010-01

304050

DIVISION OF VITAL RECORDS, 201 W PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B GIVES PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3 RETAIN IT PAGE 5 FOR YOUR FILES.

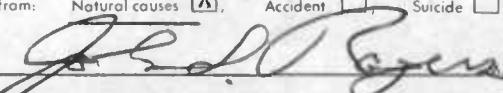
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

29063

REG. NO.

FOR  
1- STATE  
REGISTRAR

|   |         |  |   |   |                                     |   |   |  |                       |
|---|---------|--|---|---|-------------------------------------|---|---|--|-----------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |         | FIRST<br>Robert  | MIDDLE<br>Lee                                 | LAST<br>Hunter  | 2a. DATE KNOWN<br>OF ESTI-<br>MATED | MONTH<br>10/25  | DAY<br>1985                                       | YEAR<br>12:00<br>Noon                        |                       |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH<br>MONTH DAY YEAR   | 6. AGE (IN YEARS<br>LAST BIRTHDAY)<br>62 YRS. | 7. IF UNDER 1 YR.<br>MONTHS<br>DAYS   | 8. IF UNDER 24 HRS.<br>HOURS<br>MIN | 2c. DATE<br>PRONOUNCED<br>DEAD  | MONTH<br>10/25                                    | DAY<br>1985                                  | YEAR<br>12:00<br>Noon |
| Male  | Black   | Apr. 21, 1923  |   |   |                                     |   |   |  |                       |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?   |   | 8. MARRIED<br><input checked="" type="checkbox"/> NEVER MARRIED<br><input type="checkbox"/> WIDOWED<br><input checked="" type="checkbox"/> DIVORCED |                                     | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County   |   |  |                       |
| North Carolina  |         | USA  |   |   |                                     | MD.   |   |  |                       |
| 10. CITY OR TOWN OF DEATH<br>Silver Spring  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3746 Capulet Terrace |   |   |                                     | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)<br>Retired   |   | 12b. KIND OF BUSINESS<br>OR INDUSTRY<br>None |                       |
| 13a. STATE<br>Maryland  |         | 13b. COUNTY<br>Montgomery  |   | 13c. CITY OR TOWN<br>Silver Spring  |                                     | 13d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES<br><input type="checkbox"/> NO                  | 13e. STREET ADDRESS<br>3746 Capulet Terrace 20901 |  |                       |
| 14. FATHER'S NAME<br>FIRST<br>Robert  |         | MIDDLE   | LAST<br>Hunter                                | 15. MOTHER'S MAIDEN NAME<br>Unknown   |                                     |   |   |  |                       |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>Yes  |         | 16b. SOCIAL SECURITY NO.<br>Unknown  |   | 17. INFORMANT<br>Mrs. Wilhelmina Bush/daughter/same as 13e  |                                     | ADDRESS   |   |  |                       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Carcinoma of the lung.<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a) stating the <u>under-</u><br>lying cause lost.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |         |  |   |   |                                     |   |   |  |                       |
| APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>6 years  |         |  |   |   |                                     |   |   |  |                       |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I<br>None  |         |  |   |   |                                     |   |   |  |                       |
| 19a. DATE OF OPERATION<br>None  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |   |                                     | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                 |   |  |                       |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>None   |                                     |   |   |  |                       |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |         | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)   |   | 21f. LOCATION<br>STREET   |                                     | CITY OR TOWN  | COUNTY  | STATE  |                       |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion<br>death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |  |   |   |                                     |   |   |  |                       |
| ACTUAL<br>SIGNATURE<br>  |         | TITLE (SPECIFY)<br>Deputy<br>MEDICAL EXAMINER  |   |   |                                     | DATE<br>SIGNED<br>10/25/85  |   |  |                       |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>John S. Rogers, M.D.  |         | 1919 Seminary Road<br>Silver Spring, Montgomery County, Md.  |   |   |                                     |   |   |  |                       |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |         | 23b. DATE<br>10-30-85  |   | 23c. NAME OF CEMETERY OR CREMATORIAL<br>Ft. Lincoln   |                                     | 23d. LOCATION<br>CITY OR TOWN<br>Brentwood,   |   |  |                       |
| 24. FUNERAL DIRECTOR<br>NAME<br>John T. Rhines Co., 3015 12th St. N.E., D.C.  |         | ADDRESS<br>20017   |   | 25a. DATE REC'D. BY REGISTRAR<br>01/29/1985   |                                     | 25b. REGISTRAR'S SIGNATURE<br> |   |  |                       |
| 07/84<br>25M  |         | BP   |   | DHMH - 17<br>(VR A15 ME (5))  |                                     |   |   |  |                       |

UCO 003



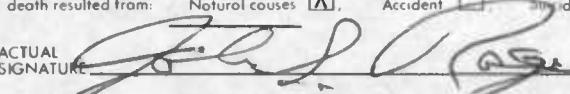
287143

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1-  
STATE  
REGISTRAR

|   |         |  |                                    |   |   |   |  |                                |                                      |                   |   |
|---|---------|--|------------------------------------|---|---|---|--|--------------------------------|--------------------------------------|-------------------|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |         |  | FIRST                              | MIDDLE  | LAST  | 2a. DATE KNOWN<br>OF ESTI-<br>DEATH MATED   | MONTH  | DAY                            | YEAR                                 | 2b. HIGH<br>P. M. |   |
| Annie Estelle Hutcherson  |         |  |                                    |   |   | <input checked="" type="checkbox"/>   | 10/3   | 19                             | 85                                   | 8:55              |   |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH<br>MONTH DAY YEAR   | 6. AGE (IN YEARS<br>LAST BIRTHDAY) | IF UNDER 1 YR.<br>MONTHS DAYS   | IF UNDER 24 HRS.<br>HOURS MIN   | 2c. DATE<br>PRONOUNCED<br>DEAD  | MONTH  | DAY                            | YEAR                                 | 2d. HIGH<br>P. M. |   |
| Female  | White   | Jul. 25, 1902  | 83 yrs.                            |   |   | <input checked="" type="checkbox"/>   | 10/3   | 19                             | 85                                   | 8:55              |   |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?   |                                    |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH           |                                |                                      |                   |   |
| Virginia  |         | USA  |                                    |   |   |   | Montgomery County                              |                                |                                      | MD                |   |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                    |   | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)  |   | 12b. KIND OF BUSINESS<br>OR INDUSTRY           |                                |                                      |                   |   |
| Silver Spring   |         | 1400 Fenwick Lane, #808,   |                                    |   | Housewife   |   | 20906  |                                |                                      |                   |   |
| 13a. STATE<br>Maryland  |         | 13b. COUNTY<br>Montgomery  |                                    | 13c. CITY OR TOWN<br>Silver Spring  |   | 13d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | 13e. STREET ADDRESS<br>1400 Fenwick Lane, #808 |                                | 12b. KIND OF BUSINESS<br>OR INDUSTRY |                   |   |
| 14. FATHER'S NAME<br>John   |         | MIDDLE   |                                    | LAST  |   | 15. MOTHER'S MAIDEN NAME<br>Elizabeth Proctor   |  |                                |                                      |                   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)   |         | 16b. SOCIAL SECURITY NO.<br>No   |                                    | 17. INFORMANT<br>Son  |   | ADDRESS<br>George E. Hutcherson   |  | Rt. 3, Box 100H<br>Orange, Va. |                                      |                   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute myocardial disease.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a) stating the <u>under-</u><br><u>lying cause last.</u>  |         |  |                                    |   |   |   |  |                                |                                      |                   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| (b)<br>DUE TO, OR AS A CONSEQUENCE OF   |         |  |                                    |   |   |   |  |                                |                                      |                   |   |
| (c)   |         |  |                                    |   |   |   |  |                                |                                      |                   |   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o).   |         |  |                                    |   |   |   |  |                                |                                      |                   |   |
| None  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |                                    |   | 20. AUTOPSY?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |   |  |                                |                                      |                   |   |
| None  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |                                    |   | 20. AUTOPSY?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |   |  |                                |                                      |                   |   |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>None |   |   |  |                                |                                      |                   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |         | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)   |                                    | 21f. LOCATION<br>STREET   |   | CITY OR TOWN  | COUNTY   | STATE                          |                                      |                   |   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion<br>death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |  |                                    |   |   |   |  |                                |                                      |                   |   |
| ACTUAL SIGNATURE   |         |  |                                    |   |   |   |  |                                |                                      |                   |   |
| EXAMINER'S NAME<br>(TYPE OR PRINT) John S. Rogers, M.D.   |         |  |                                    |   |   |   |  |                                |                                      |                   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |         | 23b. DATE<br>Oct. 6, 1985  |                                    | 23c. NAME OF CEMETERY OR CREMATORIAL<br>Graham Cemetery                               |   | 23d. LOCATION<br>CITY OR TOWN<br>Orange   |  | COUNTY STATE<br>Virginia       |                                      |                   |   |
| 24. FUNERAL DIRECTOR<br>NAME Francis J. Collins, Jr.  |         | ADDRESS<br>500 University Blvd., W. Silver Spring, Md.   |                                    | 25a. DATE REC'D. BY REGISTRAR<br>OCT 9 1985   |   | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Pendell  |  |                                |                                      |                   |   |
| BP _____  |         |  |                                    |   |   |   |  |                                |                                      |                   |   |
| DHMH - 17<br>(VR A15 ME (5))  |         |  |                                    |   |   |   |  |                                |                                      |                   |   |

SAKURAS

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311083

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8529065

REG. NO.

1 - STATE  
REGISTRAR

|   |   |   |       |  |   |   |   |  |  |         |  |
|---|---|---|-------|--|---|---|---|--|--|---------|--|
| DECEASED NAME<br>(TYPE OR PRINT)  |   |   | FIRST | MIDDLE   | LAST  | 2a DATE OF DEATH  | MONTH   | DAY                                    | YEAR   | 2b HOUR |  |
|   |   |   | Luke  | S.   | Hsen  | 10  | 29  | 85                                     |  | 4:00P   |  |
| 3. SEX  | 4. RACE   | 5. DATE OF BIRTH  |       |  | 6. AGE (IN YEARS LAST BIRTHDAY)   | IF UNDER 1 YEAR   | IF UNDER 24 HRS   |  |  |         |  |
| Male  | Chinese   | MONTH   | DAY   | YEAR   | 58  | MONTHS  | YEARS   | HOURS                                  | MIN.   |         |  |
| 7a BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |       |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |   |   |  |  |         |  |
| China   | U.S.  |   |       |  | Montgomery MD.  |   |   |  |  |         |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |       |  |   | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |   |  |  |         |  |
| Derwood   | 7607 Nut Wood Ct.   |   |       |  |   | Chef Retired Restaurant   |   |  |  |         |  |
| 13a. STATE  | 13b. COUNTY   | 13c. CITY OR TOWN   |       |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e STREET ADDRESS / ZIP CODE                                   |   |  |  |         |  |
| Md.   | Montgomery  | Derwood   |       |  |   | 7606 Nut Wood Court 20855                                       |   |  |  |         |  |
| 14. FATHER'S NAME   | FIRST   | MIDDLE  | LAST  | 15. MOTHER'S MAIDEN NAME   |   |   | 16. APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH               |  |  |         |  |
| Hsien-She   |   |   | Hsen  | Kang-Sien  |   |   | 7607 Nut Wood Ct.<br>Derwood, Md/ 20855<br>6 mos.                 |  |  |         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  | 16b. SOCIAL SECURITY NO   |   |       | 17. INFORMANT  |   |   |   |  |  |         |  |
| No  | 114-30-0931   |   |       | Paul L. Hsen   |   |   |   |  |  |         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pancreatic Carcinoma</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause lost.   |   |   |       |  |   |   |   |  |  |         |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |   |   |       |  |   |   |   |  |  |         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1   |   |   |       |  |   |   |   |  |  |         |  |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |       |  |   | 20a. AUTOPSY?   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH? |  |  |         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   |       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |   | YES <input type="checkbox"/>                                      | NO <input checked="" type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |         |  |
| 21d. INJURY OCCURRED<br><br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)                                     |   |       | 21f. LOCATION<br>STREET  |   |   | CITY OR TOWN  | COUNTY                                 | STATE  |         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>MAY</u> , 19 <u>85</u> , to <u>OCTOBER 24, 1985</u> , that (I) (we) last<br>saw the deceased alive on <u>OCTOBER 23, 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (do) did not review the body afterwards. |   |   |       |  |   |   |   |  |  |         |  |
| 22b. SIGNATURE <u>William R. Stern, M.D.</u> DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> DATE SIGNED <u>10-30-85</u>   |   |   |       |  |   |   |   |  |  |         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>William R. Stern, M.D.</u> ADDRESS <u>14820 Physicians Lane, Rockville, Md. 20850</u>  |   |   |       |  |   |   |   |  |  |         |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>Burial   | 23b. DATE<br>10/31/85   | 23c. NAME OF CEMETERY OR CREMATORIUM<br>Gate of Heaven Cemetery   |       |  | 23d. LOCATION<br>Silver Spring, Maryland  |   |   |  |  |         |  |
| 24. FUNERAL DIRECTOR<br>Tyson Wheeler Funeral Home, Inc.<br>1331 Rockville Pike, Rockville, Maryland 20852  |   |   |       |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 05 1985  | 25b. REGISTRAR'S SIGNATURE<br><u>John K. Johnson, Jr.</u>       |   |  |  |         |  |

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be filed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be informed.

311623

2001-08-08 01

near

near

34

PSM 61

density

etc

reservoir

etc

located at latitude 100°

and longitude 30°

height

depth 300 m. 000'

and showing a

bottom

100 foot sea level

not true

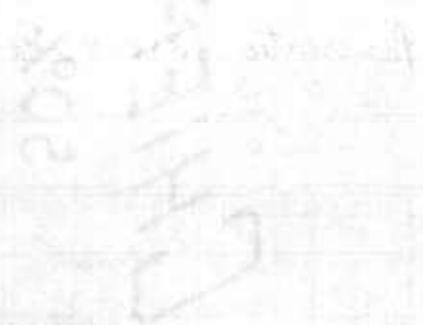
ca

etc - etc

3000 ft. 000' sea level

depth 3000 ft. 000'

etc



318012

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ONE WITH FORM BM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSITIION UNIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |   |  |                                 |  |                           |  |         |  |
|--|--|--|--|--|--|--|--|---|--|---------------------------------|--|---------------------------|--|---------|--|
| 1 - STATE REGISTRAR  |  | 2a DATE KNOWN TO MONTH DAY YEAR<br>OF ESTI. DEATH MATED Oct-30 1985 2005   |  |  |  |  |  |   |  |                                 |  |                           |  | 2b HOUR |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST  |  | MIDDLE   |  | LAST   |  | 2c DATE PRONOUNCED DEAD<br>MONTH DAY YEAR     |  | 2d HOUR                         |  |                           |  |         |  |
| 3. SEX F   |  | 4 RACE N   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Oct-18-05 80   |  | 6 AGE (IN YEARS)<br>LAST BIRTHDAY<br>YRS.  |  | 7 IF UNDER 1 YR.<br>MONTHS DAYS               |  | 8 IF UNDER 24 HRS.<br>HOURS MIN |  | 2e DATE<br>MONTH DAY YEAR |  |         |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia  |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.  |  | 2f DATE<br>MONTH DAY YEAR                     |  | 2g HOUR                         |  |                           |  |         |  |
| 10. CITY OR TOWN OF DEATH Takoma Park  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Takoma Park Advent. Hosp  |  | 12a USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE) Housewife  |  | 12b KIND OF BUSINESS OR INDUSTRY   |  |   |  |                                 |  |                           |  |         |  |
| 13a. STATE Md.   |  | 13b. COUNTY Montgomery   |  | 13c. CITY OR TOWN  |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e STREET ADDRESS<br>20903 187-2115 Regis Rd |  |                                 |  |                           |  |         |  |
| 14. FATHER'S NAME FIRST John   |  | MIDDLE M.  |  | 15. MOTHER'S MAIDEN NAME LAST<br>Sarah Lee   |  |  |  |   |  |                                 |  |                           |  |         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) No   |  | 16b. SOCIAL SECURITY NO. 705-44-9768   |  | 17. INFORMANT<br>Phyllis L. Bolejack - above address<br>(Dtr.)   |  | ADDRESS  |  |   |  |                                 |  |                           |  |         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Acute myocardial dis-   |  | DUE TO, OR AS A CONSEQUENCE OF   |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH  |  |   |  |                                 |  |                           |  |         |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |  | (b) DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |   |  |                                 |  |                           |  |         |  |
| (c) None   |  |  |  |  |  |  |  |   |  |                                 |  |                           |  |         |  |
| 19a. DATE OF OPERATION<br>None   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |   |  |                                 |  |                           |  |         |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |   |  |                                 |  |                           |  |         |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |                                 |  |                           |  |         |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> |  | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion<br>Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |  |  |   |  |                                 |  |                           |  |         |  |
| ACTUAL SIGNATURE   |  | TITLE (SPECIFY)  |  | MEDICAL EXAMINER   |  |  |  |   |  |                                 |  |                           |  |         |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |  | ADDRESS  |  | DATE SIGNED<br>Oct-13-1985   |  |  |  |   |  |                                 |  |                           |  |         |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) Burial  |  | 23b. DATE 11/2/1985  |  | 23c. NAME OF CEMETERY OR CREMATORIAL Riverview Cem.  |  | 23d. LOCATION CITY OR TOWN Charlottesville-Albermarle  |  | COUNTY STATE                                  |  |                                 |  |                           |  |         |  |
| 24. FUNERAL DIRECTOR NAME<br>Valley's F. H. Inc.   |  | ADDRESS Mt. Rainier, Md.   |  | 25a. DATE REC'D. BY REGISTRAR Nov 04 1985  |  | 25b. REGISTRAR'S SIGNATURE   |  | Va.   |  |                                 |  |                           |  |         |  |

316210



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remit cashiers' checks to the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or if item 18, 19, 20, 21, 22, 23, 24, 25, any injury, an other traumatic event, the medical examiner will be notified at once.

## MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

852906

REG. NO.

|  |  |   |        |   |                          |   |       |  |      |                        |  |
|--|--|---|--------|---|--------------------------|---|-------|--|------|------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   | FIRST  | MIDDLE  | LAST                     | 2a. DATE OF DEATH   | MONTH | DAY  | YEAR | 2b. HOUR               |  |
| MARTIN   |  |   |        |   | JACOBS                   | Oct. 6, 1985  |       |  |      | 3:30a.m.               |  |
| 3. SEX   |  | 4. RACE   |        | 5. DATE OF BIRTH<br>MONTH DAY YEAR  |                          | 6. AGE (IN YEARS LAST BIRTHDAY)   |       | IF UNDER 1 YEAR  |      | IF UNDER 24 HRS        |  |
| Male   |  | White   |        | Feb. 17, 1908   |                          | 77  |       | YRS  |      | MONTHS DAYS HOURS MIN. |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                          | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.  |       |  |      |                        |  |
| New York   |  | USA   |        |   |                          |   |       |  |      |                        |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |        | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |                          | 12b. KIND OF BUSINESS OR INDUSTRY   |       |  |      |                        |  |
| Chevy Chase  |  | 3302 Shepherd Street  |        | Physician (Ret) Medical   |                          | 20815   |       |  |      |                        |  |
| 13a. STATE   |  | 13b. COUNTY   |        | 13c. CITY OR TOWN   |                          | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>         |       | 13e. STREET ADDRESS / ZIP CODE                                 |      |                        |  |
| Maryland   |  | Montg.  |        | Chevy Chase   |                          | YES <input checked="" type="checkbox"/>   |       | 3302 Shepherd Street   |      |                        |  |
| 14. FATHER'S NAME  |  | FIRST   | MIDDLE | LAST  | 15. MOTHER'S MAIDEN NAME |   | FIRST | MIDDLE   | LAST |                        |  |
|  |  | Hyman   |        | Jacobs  | Lena                     |   |       |  |      | (unknown)              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES OR NO UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |        | 17. INFORMANT   |                          | ADDRESS   |       | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                |      |                        |  |
| Yes  |  | WW II   |        | 111-36-2542A  |                          | Ceil Jacobs, Wife; 3302 Shepherd Street   |       | Chevy Chase, Md., 20815<br>6 months                            |      |                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE 1a) <i>cachexia of cancer</i>   |  |   |        |   |                          |   |       |  |      |                        |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>cancer of renal cell</i>  |  |   |        |   |                          |   |       |  |      |                        |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>2 years</i>   |  |   |        |   |                          |   |       |  |      |                        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.  |  |   |        |   |                          |   |       |  |      |                        |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |        |   |                          | 20a. AUTOPSY?   |       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |      |                        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)  |                          | YES <input type="checkbox"/> <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> |       | YES <input type="checkbox"/> NO <input type="checkbox"/>       |      |                        |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |        | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                          |   |       |  |      |                        |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>8/15</i> , 19 <i>85</i> , to <i>10/6</i> , 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>8/15</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |        |   |                          |   |       |  |      |                        |  |
| 22b. SIGNATURE<br><i>Bruce A. Silver, M.D.</i>   |  | DEGREE  |        | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |                          | 22c. DATE SIGNED<br>10-6-1985   |       |  |      |                        |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>BRUCE A. SILVER, M.D.   |  | 22e. ADDRESS<br>106 Irving Street NW; Wash., D.C.   |        |   |                          |   |       |  |      |                        |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>10-9-85  |        | 23c. NAME OF CEMETERY OR CREMATORIUM<br>Mt. Ararat Cemetery Farmingdale, N.Y.   |                          | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |       |  |      |                        |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Danzansky-Goldberg Chapels   |  | Rockville, Maryland   |        | 25a. DATE REC'D. BY REGISTRAR<br>8/7/14 1:45 PM   |                          | 25b. REGISTRAR'S SIGNATURE<br><i>Julia K. Johnson</i>   |       |  |      |                        |  |
| 1170 Rockville Pike  |  |   |        |   |                          |   |       |  |      |                        |  |

10000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the Burial/Transit Permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked **o**, item 1B shows any injury, or other traumatic event, in medical except

309015

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - STATE  
REGISTRAR

|   |  |  |   |   |   |   |  |  |  |  |                                     |                              |  |
|---|--|--|---|---|---|---|--|--|--|--|-------------------------------------|------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  | FIRST<br><b>THOMAS</b>  | MIDDLE<br><b>HERBERT</b>                                  | LAST<br><b>JAMES</b>  | 2a DATE OF DEATH<br><b>OCTOBER 29, 1985</b>   | MONTH<br>YEAR  | DAY  | YEAR   | 2b HOUR<br><b>4:55 a.m.</b>                        |                                     |                              |  |
| 3. SEX  |  |  | 4. RACE   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>JULY 9, 1952</b> |   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>33</b><br>YRS                                  |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS                     |                                     | IF UNDER 24 HRS<br>HOURS MIN |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Illinois</b>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>  |   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY COUNTY, MD.</b>  |  |                                     |                              |  |
| 10. CITY OR TOWN OF DEATH<br><b>BETHESDA</b>  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>CLINICAL CENTER (NIH)</b> |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Program Analyst</b>  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Computer</b>   |  |                                     |                              |  |
| 13a. STATE<br><b>MARYLAND</b>   |  |  | 13c. CITY OR TOWN<br><b>Prince George's TEMPLE HILLS</b>  |   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  | 13e. STREET ADDRESS / ZIP CODE<br><b>3204 CARLTON AVE 20748</b>  |  |                                     |                              |  |
| 14. FATHER'S NAME<br>FIRST<br><b>Donald</b>   |  |  | MIDDLE<br><b>L.</b>   | LAST<br><b>James</b>                                      | 15. MOTHER'S MAIDEN NAME<br>FIRST<br><b>June</b>                              |   |  | MIDDLE<br><b>I.</b>                              | LAST<br><b>Hannon</b>  | ADDRESS<br><b>1633 N. 77th ct Elmwood Park, IL</b> |                                     |                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>N/A</b>  |   |   | 17. INFORMANT<br><b>MR. DONALD L. JAMES (FATHER)</b>  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH  |  |                                     |                              |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b>  |  |  |   |   |   |   |  |  |  |  |                                     |                              |  |
| DUE TO, OR AS A CONSEQUENCE OF<br><b>PNEUMOCYSTIS PNEUMONIA</b><br>(b)  |  |  |   |   |   |   |  |  |  |  |                                     |                              |  |
| DUE TO, OR AS A CONSEQUENCE OF<br><b>ACQUIRED IMMUNODEFICIENCY SYNDROME</b><br>(c)  |  |  |   |   |   |   |  |  |  |  |                                     |                              |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a  |  |  |   |   |   |   |  |  |  |  |                                     |                              |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   |   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                                     |                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                   |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |   |  |  |  |  |                                     |                              |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                       |   |   | 21f. LOCATION<br>STREET   |   |  | CITY OR TOWN                                     | COUNTY   | STATE  |                                     |                              |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from _____, 19_____, to <b>OCT. 29, 1985</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>OCT. 29, 1985</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input type="checkbox"/> (not) view the body after death. |  |  |   |   |   |   |  |  |  |  |                                     |                              |  |
| 22b. SIGNATURE <b>Philip Murphy MD</b> DEGREE   |  |  |   |   |   |   |  |  |  |  |                                     |                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Philip Murphy MD</b>  |  | 22e. ADDRESS<br><b>NATIONAL INSTITUTES OF HEALTH<br/>CLINICAL CENTER, BETHESDA, MD 20205</b> |   |   | ATTENDING PHYSICIAN <input type="checkbox"/>                                  |   | MEDICAL DIRECTOR <input type="checkbox"/>  |  | STAFF PHYSICIAN <input checked="" type="checkbox"/>  |  | 22f. DATE SIGNED<br><b>10/29/85</b> |                              |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>October 31, 1985</b>   |   |   | 23c. NAME OF CEMETERY OR CREMATORIUM<br><b>Queen of Heaven</b>                |   |  | 23d. LOCATION<br>CITY OR TOWN<br><b>Hillside</b> |  |  | COUNTY<br><b>Cook</b>               | STATE<br><b>Illinois</b>     |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>P.A. 7557 Wisconsin Ave., Bethesda, MD</b>   |  | 25. DATE REC'D. BY REGISTRAR<br><b>NOV 01 1985</b>   |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Robert A. Pumphrey Funeral Homes</b>         |   |  |  |  |  |                                     |                              |  |

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303113

1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |       |   |         |   |                          |  |                                      |   |  |
|---|--|--|-------|---|---------|---|--------------------------|--|--------------------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  | FIRST | MIDDLE  | LAST    | 2a. DATE OF DEATH   | MONTH                    | DAY  | YEAR                                 | 2b. HOUR  |  |
| VICTOR  |  |  | W.    |   | JAMISON | OCT. 11, 1985   |                          |  |                                      | 3:15A M   |  |
| 3. SEX  |  | 4. RACE  |       | 5. DATE OF BIRTH  |         | 6. AGE  | (IN YEARS LAST BIRTHDAY) |  | IF UNDER 1 YEAR                      |   |  |
| MALE  |  | BLACK  |       | MONTH   | DAY     | YEAR  | MONTHS                   | YEARS  | MONTHS                               | YEARS   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |       | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |         | 9. BALTIMORE CITY OR COUNTY OF DEATH                                      |                          |  |                                      |   |  |
| SOUTH CAROLINA  |  | U.S.A.   |       |   |         | MONTGOMERY  |                          |  |                                      |   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(DO NOT INCLUDE FACILITY CODE STREET ADDRESS) |       | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |         |   |                          |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY |   |  |
| SILVER SPRING   |  | HOLY CROSS HOSPITAL  |       | LABORER   |         |   |                          |  | CONSTRUCTION                         |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |       |   |         | 13b. CITY OR TOWN   |                          |  |                                      |   |  |
| IN COUNTY   |  |  |       |   |         | WASHINGTON, D.C.  |                          |  |                                      |   |  |
| 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |       |   |         | 13d. STREET ADDRESS / ZIP CODE<br>645 KEEFER PL. NW 20001                 |                          |  |                                      |   |  |
| 14. FATHER'S NAME<br>FIRST  |  | MIDDLE   |       | LAST  |         | 15. MOTHER'S MAIDEN NAME<br>FIRST   |                          | MIDDLE   |                                      | LAST  |  |
| William   |  | -  |       | WILSON  |         | GLADYS  |                          | -  |                                      | TAYLOR  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |       | 17. INFORMANT   |         | 18. CAUSE OF DEATH<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) |                          | ADDRESS  |                                      | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                     |  |
| YES   |  | WWII   |       | UNKNOWN   |         | Victor E. Jamison (son)   |                          | 709 TUCKERMAN ST. NW<br>WASHINGTON, D.C.   |                                      | immediate   |  |
| 19. MEDICAL CERTIFICATION   |  |  |       |   |         |   |                          |  |                                      |   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause last  |  |  |       |   |         |   |                          |  |                                      |   |  |
| (b) _____   |  |  |       |   |         |   |                          |  |                                      |   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |  |       |   |         |   |                          |  |                                      |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a  |  |  |       |   |         |   |                          |  |                                      |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |       |   |         | 20a. AUTOPSY?   |                          | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                      |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |         |   |                          |  |                                      | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                   |       | 21f. LOCATION<br>STREET   |         | CITY OR TOWN  |                          | COUNTY   |                                      | STATE   |  |
| 22a. I certify that (I) (chamberlain) attended the deceased from 19 82 to 11 00, to 19 85, that we last<br>saw the deceased alive on 6 OCT 19 85 and that in our opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) did not view the body after death. |  |  |       |   |         |   |                          |  |                                      |   |  |
| 22b. SIGNATURE<br><i>Walter E. Goode MD</i>   |  | DEGREE   |       | ATTENDING<br>PHYSICIAN <input checked="" type="checkbox"/> MEDICAL<br>DIRECTOR <input type="checkbox"/> STAFF<br>PHYSICIAN <input type="checkbox"/>         |         | 22c. DATE SIGNED<br>11 OCT 85   |                          |  |                                      |   |  |
| 22d. PHYSICIAN'S NAME<br>(TYPE OR PRINT)  |  | 22e. ADDRESS<br>2309 SHOREFIELD RD WHEATON, MD   |       |   |         |   |                          |  |                                      |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE<br>OCT. 18, 1985   |       | 23c. NAME OF CEMETERY OR CREMATORIAL<br>CHAMBERS CEMETERY   |         | 23d. LOCATION<br>RIVERDALE, PG Co, Maryland                               |                          |  |                                      |   |  |
| 24. FUNERAL DIRECTOR<br>NAME  |  | ADDRESS  |       | 25a. DATE REC'D. BY REGISTRAR<br>OCT 23 1985  |         | 25b. REGISTRAR'S SIGNATURE  |                          |  |                                      |   |  |
| CHAMBERS FUNERAL HOME SILVER SPRING, MD.  |  |  |       |   |         |   |                          |  |                                      |   |  |

O. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it may be retained by the hospital or attending physician.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

CLICOS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be resumed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please return to me in person. Pages 1 and 2 should be detached for use on the burial permit. Then please return to me in person. Page 1 and 2 should be filled within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |   |  | 85 29075  |  |   |  |
|--|--|--|---|---|--|---|--|---|--|
|  |  |  |   |   |  | REG. NO.  |  |   |  |
| 1. FOR<br>STATE<br>REGISTRAR   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR  |   |  | 2b. HOUR  |  |   |  |
| 1. DECEASED NAME<br><small>TYPE OR PRINT</small><br>Jeffries, Vincent  |  |  | LAST  |   |  | 10 - 28-85 1245 AM  |  |   |  |
| 3. SEX<br><small>M</small>   |  | 4. RACE<br><small>B</small>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><small>4 9 52</small>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><small>32 YRS</small>  |  | 7b. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7. BIRTHPLACE<br><small>ESTATE OR FOREIGN COUNTRY<br/>D.C.</small>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><small>U.S.</small>                    |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><small>TOKOMA PARK MONT. Co. MD.</small>                |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><small>Disabled</small>  |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><small>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)</small><br>Takoma Park Washington Adventist Hosp                                    |  |  |   |   |  | 12a. USUAL OCCUPATION<br><small>(TYPE OF WORK FOR MOST OF WORKING LIFE)</small><br>Disabled     |  |   |  |
| 13a. STATE<br><small>D.C.</small>  |  | 13b. COUNTY<br><small>D.C.</small>                                     |   | 13c. CITY OR TOWN<br><small>D.C.</small>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><small>1441 Primrose Rd N.W.</small>  |  |
| 14. FATHER'S NAME<br><small>FIRST MIDDLE LAST</small><br>Melvin Jeffries   |  |  | 15. MOTHER'S MAIDEN NAME<br><small>FIRST MIDDLE LAST</small><br>ESTHER TATE |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br><small>YES NO OR UNKNOWN</small><br>NO   |  | 16b. SOCIAL SECURITY NO.<br><small>N/A</small>                         |   | 17. INFORMANT<br><small>MELVIN JEFFRIES 1441 PRIMROSE RD N.W.</small>   |  | ADDRESS   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Respiratory Arrest   |  |  |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) Acquired Immune Deficiency Syndrome  |  |  |   |   |  |   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |  |   |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a   |  |  |   |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br><small>WHILE AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></small>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/27 1985 to 10/28 1985, that (I) (we) last saw the deceased alive on above, (I) (we) (did) (did not) view the body after death. |  |  |   |   |  |   |  |   |  |
| 22b. SIGNATURE<br><small>Phyllis Schreiner MD</small>  |  | DEGREE   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                          |  | 22c. DATE SIGNED<br><small>10/28/85</small>   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><small>Phyllis Schreiner MD</small>   |  | 22e. ADDRESS<br><small>Kaiser Health 8300 Corporate Drive</small>      |   |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  | 23b. DATE<br>10/31/85  |   | 23c. NAME OF CEMETERY OR CREMATORIAL<br>HARMONY MEMORIAL PARK LANDOVER P.G. MARYLAND STATE  |  | 23d. LOCATION   |  |   |  |
| 24. FUNERAL DIRECTOR<br><small>NAME<br/>J.B.JENKINS F.H. 7474 LANDOVER RD LANDOVER MD</small>  |  | 25a. DATE REC'D. BY REGISTRAR<br><small>Oct 31 1985</small>            |   | 25b. REGISTRAR'S SIGNATURE<br><small>J.B.JENKINS F.H.</small>   |  |   |  |   |  |
| 99999  |  |  |   |   |  |   |  |   |  |

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**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH**

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|  |                   |   |  |  |   |   |                                      |   |             |                  |             |
|--|-------------------|---|--|--|---|---|--------------------------------------|---|-------------|------------------|-------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |                   |   | FIRST  | MIDDLE   | LAST  | 20. DATE OF DEATH   | MONTH                                | DAY   | YEAR        | 2b HOUR          |             |
| <b>LAIRD</b>   |                   |   | <b>S.</b>  | <b>JERMAN, SR.</b>   |   | <b>OCTOBER 1, 1985</b>  |                                      |   |             | <b>1:15 AM</b>   |             |
| 3. SEX   |                   | 4. RACE   | 5. DATE OF BIRTH   |  |   | 6. AGE (IN YEARS LAST BIRTHDAY)   |                                      | IF UNDER 1 YEAR   |             | IF UNDER 24 HRS. |             |
| <b>MALE</b>  |                   | <b>CAUCASIAN</b>  | <b>APRIL 29, 1928</b>  |  |   | <b>57 yrs</b>   |                                      | <b>MONTHS</b>   | <b>DAYS</b> | <b>HOURS</b>     | <b>MIN.</b> |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN)   |                   | 7b. CITIZEN OF WHAT COUNTRY?  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH |   |             |                  |             |
| <b>WASHINGTON, DC</b>  |                   | <b>U.S.A.</b>   |  |  |   |   | <b>MONTGOMERY</b>                    |   |             |                  |             |
| 10. CITY OR TOWN OF DEATH  |                   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |   | 12b. KIND OF BUSINESS OR INDUSTRY    |   |             |                  |             |
| <b>OLNEY</b>   |                   | <b>2 DARNELL COURT</b>  |  |  | <b>SECURITY GUARD</b>   |   |                                      |   |             |                  |             |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |                   |   |  |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                      |   |             |                  |             |
| 13a. STATE   | 13b. COUNTY       | 13c. CITY OR TOWN   | 13e. STREET ADDRESS / ZIP CODE                               |  |   |   |                                      |   |             |                  |             |
| <b>MARYLAND</b>  | <b>MONTGOMERY</b> | <b>OLNEY</b>  | <b>2 DARNELL COURT 20832</b>                                 |  |   |   |                                      |   |             |                  |             |
| 14. FATHER'S NAME<br><small>(FIRST MIDDLE LAST)</small>  |                   |   | 15. MOTHER'S MAIDEN NAME<br><small>FIRST MIDDLE LAST</small> |  |   |   |                                      |   |             |                  |             |
| <b>JOHN</b>  |                   |   | <b>MYRTLE</b>  |  |   |   |                                      |   |             |                  |             |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(IF UNKNOWN, GIVE WAR OR DATES)  |                   | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT  |   | ADDRESS   |                                      |   |             |                  |             |
| <b>NO</b>  |                   | <b>579-26-4327</b>  |  | <b>JEAN S. JERMAN</b>  |   | <b>SAME AS 13 WIFE</b>  |                                      |   |             |                  |             |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)  |                   |   |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |                                      |   |             |                  |             |
| <b>Cardio - Respiratory arrest.</b>  |                   |   |  |  |   |   |                                      |   |             |                  |             |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Cong, due to respiratory failure</b>  |                   |   |  |  |   |   |                                      |   |             |                  |             |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause last<br>(c) <b>Anemia. Metastatic Disease</b>  |                   |   |  |  |   |   |                                      |   |             |                  |             |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |                   |   |  |  |   |   |                                      |   |             |                  |             |
| 19a. DATE OF OPERATION   |                   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |   | 20a. AUTOPSY?   |                                      | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH? |             |                  |             |
|  |                   |   |  |  |   | YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                      | YES <input type="checkbox"/> NO <input type="checkbox"/>          |             |                  |             |
| 21a. ACCIDENT WAS UNDERLYING<br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |                   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |   |   |                                      |   |             |                  |             |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>  |                   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET  |   | CITY OR TOWN  |                                      | COUNTY  |             | STATE            |             |
| 22a. I certify that (I) (this hospital) attended the deceased from 1984 to Oct 1, 1985, that (I) (we) last<br>saw the deceased alive on 29th Oct 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) did/did not view the body after death. |                   |   |  |  |   |   |                                      |   |             |                  |             |
| 22b. SIGNATURE<br><i>Hamid Montakhab</i>   |                   | DEGREE<br><i>MD</i>   |  | ATTENDING<br>PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF<br>PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>Oct. 1. 85</b>   |                                      |   |             |                  |             |
| 22d. PHYSICIAN'S NAME<br>(TYPE OR PRINT)   |                   | 22e. ADDRESS  |  | 22f. ADDRESS   |   |   |                                      |   |             |                  |             |
| <b>HAMID MONTAKHAB, M.D.</b>   |                   | <b>6111 EXEC. BLVD., ROCKVILLE, MD. 20852</b>   |  |  |   |   |                                      |   |             |                  |             |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |                   | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORIAL   |   | 23d. LOCATION<br>CITY OR TOWN   |                                      | COUNTY  |             | STATE            |             |
| <b>BURIAL</b>  |                   | <b>10/4/85</b>  |  | <b>CEDAR HILL CEMETERY SUITLAND</b>  |   | <b>PRI GEO MD.</b>  |                                      |   |             |                  |             |
| 24. FUNERAL DIRECTOR<br>NAME   |                   | ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE  |                                      |   |             |                  |             |
| <b>FRANCIS J. COLLINS</b>  |                   | <b>500 UNIV. BLVD., W., SILVER SPRING, MD.</b>  |  | <b>OCT 2 1985</b>  |   | <i>India Saiedan</i>  |                                      |   |             |                  |             |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the funeral director page 3.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial permit page. Then please remove without reprint. Pages 1 and 2 should be retained by the funeral director for 72 hours after death.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

85 29012

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and should be detached for use as the burial permit. Then please remove carbon papers. Page 3 with the State Dept. of Health and Mental Hygiene prior to burial, removal, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

|   |  |   |       |   |      |   |          |  |              |  |  |  |  |
|---|--|---|-------|---|------|---|----------|--|--------------|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   | FIRST | MIDDLE  | LAST | 2a. DATE OF DEATH   | MONTH    | DAY  | YEAR         | 2b. HOUR   |  |  |  |
| <u>HAZEL M. JOHNSON</u>   |  |   |       |   |      | <u>10</u>   | <u>2</u> | <u>85</u>  | <u>10 18</u> |  |  |  |  |
| 3. SEX  |  | 4. RACE   |       | 5. DATE OF BIRTH  |      | 6. AGE (IN YEARS LAST BIRTHDAY)   |          | IF UNDER 1 YEAR  |              | IF UNDER 24 HRS  |  |  |  |
| <u>FEMALE</u>   |  | <u>WHITE</u>  |       | MONTH <u>MARCH</u> DAY <u>17</u> YEAR <u>1899</u>   |      | 86 YRS  |          | MONTHS <u>0</u> DAYS <u>0</u>  |              | HOURS <u>10</u> MIN. <u>AM</u>   |  |  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |       | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |      | 9. BALTIMORE CITY OR COUNTY OF DEATH  |          | MD   |              |  |  |  |  |
| <u>WASHINGTON, D.C.</u>   |  | <u>U.S.A.</u>   |       |   |      | <u>MONTGOMERY</u>   |          |  |              |  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |       |   |      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                    |          | 12b. KIND OF BUSINESS OR INDUSTRY  |              |  |  |  |  |
| <u>BETHESDA</u>   |  | <u>SUBURBAN HOSPITAL</u>  |       |   |      | <u>FED GOVT (REF)</u>   |          |  |              |  |  |  |  |
| 13a. STATE<br><u>MD.</u>  |  |   |       |   |      | 13b. COUNTY<br><u>MONT.</u>   |          | 13c. CITY OR TOWN<br><u>CHERRY CHASE</u>   |              | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><u>7306 BRENNAN LANE 20015</u> |  |
| 14. FATHER'S NAME<br>FIRST  |  | MIDDLE  |       | LAST  |      | 15. MOTHER'S MAIDEN NAME<br>FIRST   |          | MIDDLE   |              | LAST   |  |  |  |
| <u>HENRY</u>  |  | <u>HOLLOWELL</u>  |       | <u>LEIZEAR</u>  |      | <u>DORA</u>   |          |  |              |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   |       | 16c. INFORMANT  |      | 16d. ADDRESS  |          | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH  |              |  |  |  |  |
| <u>NO</u>   |  | <u>212-54-6855</u>  |       | <u>Gloria Schmidt, 2214 Phelps Rd Adelphi, MD</u>   |      |   |          | <u>one month</u>   |              |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 18a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)   |  |   |       |   |      | DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>ASHD</u>   |          |  |              |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c)  |  |   |       |   |      | DUE TO, OR AS A CONSEQUENCE OF  |          |  |              |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>Chronic Bronchitis, emphysema, and asthma</u>  |  |   |       |   |      |   |          |  |              |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |       |   |      | 20a. AUTOPSY?   |          | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |              |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |       |   |      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)<br>19 29 10 - 2 19 85 |          |  |              | YES <input type="checkbox"/> NO <input type="checkbox"/>                             |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |       |   |      | 21f. LOCATION<br>STREET   |          | CITY OR TOWN   |              | COUNTY STATE   |  |  |  |
| 22a. I certify that <u>Julia Davidson</u> attended the deceased from <u>9-23</u> 19 <u>85</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. I (we) did not view the body after death. |  |   |       |   |      | 22b. DATE SIGNED<br><u>10/2/85</u>  |          |  |              |  |  |  |  |
| 22c. SIGNATURE<br><u>Julia Davidson</u>   |  | DEGREE<br><u>R.D.</u>   |       | MD  |      | ATTENDING PHYSICIAN <input type="checkbox"/>  |          | MEDICAL DIRECTOR <input type="checkbox"/>  |              | STAFF PHYSICIAN <input type="checkbox"/>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>J. SSAIA</u>  |  | 22e. ADDRESS<br><u>8094 Kings Mill Rd Rockville</u>   |       |   |      |   |          |  |              |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIES)  |  | 23b. DATE<br><u>Oct. 4, 1985</u>  |       | 23c. NAME OF CEMETERY OR CREMATORIUM<br><u>St. John Evangelical Cemetery</u>  |      | 23d. LOCATION<br>CITY OR TOWN<br><u>Oney</u>  |          | COUNTY   |              | STATE  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>Tolson Funeral Home, J. A. Tolson, 254 Carroll Hwy, DC</u>   |  | ADDRESS   |       | 25a. DATE REC'D. BY REGISTRAR<br><u>OCT 4 1985</u>  |      | 25b. REGISTRAR'S SIGNATURE<br><u>Julia Davidson Rendall</u>   |          |  |              |  |  |  |  |

about

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be delivered to you or to the Bureau of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical certificate must be signed by a physician.

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**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH**

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |   |   |   |  |   |        |   |   |   |  |
|---|--|---|---|---|--|---|--------|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   | FIRST   | MIDDLE  | LAST   | 2a. DATE OF DEATH   | MONTH  | DAY   | YEAR  | 2b. HOUR  |  |
|   |  |   | Mark  | Edward  | Johnson  | October 16, 1985  |        |   |   | 11:02AM   |  |
| 3. SEX  |  | 4. RACE   |   | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |        |   |   | 7. IF UNDER 1 YEAR  |  |
| Male  |  | Caucasian   |   | Month Day Year<br>October 16, 1955  |  | 30 YRS  |        |   |   | IF UNDER 24 HRS<br>MONTHS DAYS HOURS MIN.                         |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |        |   |   | MD.   |  |
| Washington, D.C.  |  | United States   |   |   |  | Montgomery County   |        |   |   |   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |        |   |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY                              |  |
| Gaithersburg  |  | 10112 Kindly Court  |   |   |  | Electrician   |        |   |   | Electrical  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |   |   |  | 13e. STREET ADDRESS / ZIP CODE  |        |   |   |   |  |
| 13a. STATE  |  | 13b. COUNTY   |   | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |        | 13e. STREET ADDRESS / ZIP CODE                                      |   |   |  |
| Maryland  |  | Montgomery  |   | Gaithersburg  |  |   |        | 10112 Kindly Court / 20879  |   |   |  |
| 14. FATHER'S NAME<br>FIRST  |  | MIDDLE  |   | LAST  | 15. MOTHER'S MAIDEN NAME<br>FIRST  |   | MIDDLE |   | LAST  |   |  |
| James   |  | F.  |   | Johnson   | Mary   |   |        |   | Ford  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES) |   |  | 17. INFORMANT   |        |   | ADDRESS                                     |   |  |
| No  |  |   | 217-70-8275   |   |  | Susan M. Johnson, Sister,   |        |   | 10401 Grosvenor Place, Rockville, MD. 20852 |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)  |  |   |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |        |   |   |   |  |
| <b>RESPIRATORY FAILURE</b>  |  |   |   |   |  | <b>IMMEDIATE</b>  |        |   |   |   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>FLUID + ELECTROLITE IMBALANCE</b>  |  |   |   |   |  | 2 WKS   |        |   |   |   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>WIDE SPREAD METASTATIC MELANOMA</b>  |  |   |   |   |  | 8 MO  |        |   |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a  |  |   |   |   |  |   |        |   |   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   |  |   |        | 20a. AUTOPSY?   |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH? |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   |   | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |   |        | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | YES <input type="checkbox"/> NO <input type="checkbox"/>          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)                                     |   |   | 21f. LOCATION<br>STREET  |   |        | CITY OR TOWN  |   | COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/19, 1985, to 10/16, 1985, that (I) (we) last saw the deceased alive on 10/10, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not see the body after death, check here) |  |   |   |   |  |   |        |   |   |   |  |
| 22b. SIGNATURE  |  | 22c. DATE SIGNED  |   | DEGREE  |  | ATTENDING<br>PHYSICIAN  |        | MEDICAL<br>DIRECTOR   |   | STAFF<br>PHYSICIAN  |  |
| <i>Richard P. Delaney, M.D.</i>   |  | 10/16/85  |   |   |  | <input checked="" type="checkbox"/>   |        | <input type="checkbox"/>  |   | <input type="checkbox"/>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS  |   | 22f. DATE SIGNED  |  |   |        |   |   |   |  |
| Richard P. Delaney, M.D.  |  | 4323 Havard Street, Silver Spring, Md. 20906  |   | 10/16/85  |  |   |        |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORIAL<br>ADDRESS   |  | 23d. LOCATION<br>CITY OR TOWN   |        | 23e. COUNTY   |   | 23f. STATE  |  |
| Burial  |  | October 19, 1985  |   | St. Mark's Episcopal<br>Church Cemetery   |  | Silver Spring   |        | County  |   | State   |  |
| 24. FUNERAL DIRECTOR<br>NAME  |  | Robert A. Pumphrey Funeral Homes,<br>P.A., 300 West Montgomery Ave., Rockville, MD.                       |   | ADDRESS   |  | 25d. DATE REC'D. BY REGISTRAR   |        | 25e. REGISTRAR'S SIGNATURE  |   |   |  |
| BP  |  |   |   |   |  |   |        |   |   |   |  |
| DHMH - 16 60M 7-B4<br>(VRA 15, 4)   |  |   |   |   |  |   |        |   |   |   |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - STATE REGISTRAR

|   |  |  |   |   |  |  |  |                                     |                   |                   |  |  |
|---|--|--|---|---|--|--|--|-------------------------------------|-------------------|-------------------|--|--|
| DECEASED NAME<br>(TYPE OR PRINT)  |  |  |   | FIRST<br><b>BRENDA</b>                                    | MIDDLE<br><b>Joy</b>   | LAST<br><b>JONES</b>   | 2d. DATE OF DEATH<br><b>10 17 85</b>     | MONTH<br><b>10</b>                  | DAY<br><b>17</b>  | YEAR<br><b>85</b> | 2b. HOUR<br><b>1655 M</b>                                    |  |
| 3. SEX<br><b>FEMALE</b>   | 4 RACE<br><b>WHITE</b>   | S. DATE OF BIRTH<br>MONTH<br><b>09</b>   | DAY<br><b>19</b>  | YEAR<br><b>50</b>   | 6 AGE<br>IN YEARS (LAST BIRTHDAY)<br><b>35</b>                                       | IF UNDER 1 YEAR<br>MONTHS<br><b>YRS</b>  | IF UNDER 24 HRS<br>MONTHS<br><b>0</b>    | DAYS<br><b>0</b>                    | HOURS<br><b>0</b> | MIN.<br><b>0</b>  |  |  |
| 7a. BIRTHPLACE<br>COUNTRY<br><b>WASHINGTON DC</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY COUNTY MD.</b>                  |  |  |                                     |                   |                   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>SILVER SPRING</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>HOLY CROSS HOSPITAL OF SILVER SPRING</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>WAITRESS</b>  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                                     |                   |                   |  |  |
| 13a. STATE<br><b>MD.</b>  | 13b. COUNTY<br><b>MONT.</b>  | 13c. CITY OR TOWN<br><b>WHEATON</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>4230 Roundhill Road</b>                                    | ZIP CODE<br><b>20902</b>   |  |                                     |                   |                   |  |  |
| 14. FATHER'S NAME<br>FIRST<br><b>HENRY</b>  | MIDDLE<br><b>G.</b>  | LAST<br><b>BRYANT</b>  | 15. MOTHER'S MAIDEN NAME<br>FIRST<br><b>NAN</b>   |   | MIDDLE<br><b>E.</b>  | LAST<br><b>CARRICK</b>   |  |                                     |                   |                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES OR UNKNOWN)<br><b>No</b>   | 16b. SOCIAL SECURITY NO.   | 17. INFORMANT<br><b>HENRY G. BRYANT. 415 BUTTERNOT ST. N.W.</b>  |   | ADDRESS   |  |  |  |                                     |                   |                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute respiratory distress syndrome</b>  |  |  |   |   |  |  |  |                                     |                   |                   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>6J</b> |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Septic</b>   |  |  |   |   |  |  |  |                                     |                   |                   | <b>8J</b>  |  |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause lost  |  |  |   |   |  |  |  |                                     |                   |                   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Septic failure</b>   |  |  |   |   |  |  |  |                                     |                   |                   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a<br><b>Intracerebral bleed, as</b>  |  |  |   |   |  |  |  |                                     |                   |                   |  |  |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                                     |                   |                   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |   |   |  |  |  |                                     |                   |                   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/>  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION<br>STREET  | CITY OR TOWN  |   | COUNTY   |  | STATE                                    |                                     |                   |                   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>OCT 9 1985</b> to <b>OCT 17 1985</b> , that (I) (we) lost<br>saw the deceased alive on <b>OCT 16 1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |   |   |  |  |  |                                     |                   |                   |  |  |
| 22b. SIGNATURE<br><b>Howard Goldkoff</b>  |  |  |   | DEGREE<br><b>MD</b>                                       | ATTENDING PHYSICIAN <input checked="" type="checkbox"/>                              | MEDICAL DIRECTOR <input type="checkbox"/>  | STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED<br><b>10/15/85</b> |                   |                   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Howard Goldkoff</b>   |  |  |   | 22e. ADDRESS<br><b>13017 Vers M.H Rd Wheaton MD 20906</b> |  |  |  |                                     |                   |                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>CREMATION</b>  |  | 23b. DATE<br><b>OCT 19, 1985</b>   | 23c. NAME OF CEMETERY OR CREMATORIAL<br><b>BALTIMORE/WASH. CEMETERY</b>                         |   | 23d. LOCATION<br>CITY OR TOWN<br><b>LAUREL, MD</b>                                   |  |  |                                     |                   |                   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Taylor Funeral Home &amp; Caskets 254 Carrollton NW</b>  |  | ADDRESS<br><b>D.C. OCT 21 1985</b>   | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 21 1985</b>   |   | 25b. REGISTRAR'S SIGNATURE   |  |  |                                     |                   |                   |  |  |
| DHMH - 16 60M 7/84<br>(VRA 15, 4)   |  |  |   |   |  |  |  |                                     |                   |                   |  |  |

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REMARKS

TOPS AND SIGHTS SET

VERTICAL DIAH 4m

CHART

W.M.

SIGHTS

20

XMAS

LINE TO NEAREST 24 FEET OF GROUND

20 XMAS 1988

20

20 XMAS 1988 VERTICAL SIGHTS TOP M-20 VERT H-20  
20 XMAS 1988 VERTICAL SIGHTS TOP M-20 VERT H-20

311158

85 29015

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - STATE  
REGISTRAR

|   |  |   |  |   |        |            |
|---|--|---|--|---|--------|------------|
| 1 DECEASED NAME FIRST MIDDLE LAST   |  |   | 2a DATE OF DEATH MONTH DAY YEAR  | 2b HOUR   |        |            |
| Mabel M. Jones  |  |   | 10-30-85   | 12:35 P   |        |            |
| 3 SEX Female  |  | 4 RACE Caucasian  | 5. DATE OF BIRTH MONTH DAY YEAR  | 6. AGE IN YEARS (LAST BIRTHDAY) IF UNDER 1 YEAR<br>76 YRS MONTHS DAYS HOURS MIN.  |        |            |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington D.C.  |  | 7b CITIZEN OF WHAT COUNTRY? U.S.A.  | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.   |        |            |
| 10 CITY OR TOWN OF DEATH Silver Spring  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital |  | 12a USUAL OCCUPATION Budget Analyst 12b KIND OF BUSINESS OR INDUSTRY US Govt.   |        |            |
| 13a STATE Maryland  |  | 13b COUNTY Montgomery   | 13c CITY OR TOWN Bethesda  | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e STREET ADDRESS / ZIP CODE 9721 Singleton Drive Beth. Md. 20817                                |        |            |
| 14 FATHER'S NAME William R. Montgomery  |  | 15. MOTHER'S MAIDEN NAME Annie Soper  |  |   |        |            |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? NO (YES OR UNKNOWN)   |  | 16b SOCIAL SECURITY NO. 577-09-1542   | 17 INFORMANT Alice J. Kabosky  | ADDRESS Mechanicville Rt. 4 Box 199 Md. 20659   |        |            |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>HEPATITIS ACUTE</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS |  |   |  |   |        |            |
| DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)                               |  |   |  |   |        |            |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |  |   |        |            |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |        |            |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)   |   |        |            |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION<br>STREET  | CITY OR TOWN  | COUNTY | STATE      |
| 22a. I certify that (I) (the deceased) attended the deceased from 29 OCT 1985 to 30 OCT 1985, that (I) (last saw the deceased alive on above, (I) (we) (did) (did not) view the body after death)             |  |   |  |   |        |            |
| 22b. SIGNATURE <u>WALTER E. GOODE MD</u>  |  | DEGREE  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               | 22c. DATE SIGNED 30 OCT 85  |        |            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>WALTER E. GOODE MD</u>   |  | 22e. ADDRESS <u>2309 SHOREFIELD RD WHEATON MD</u>   |  |   |        |            |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial  |  | 23b. DATE Nov. 4, 1985  | 23c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet  | 23d. LOCATION CITY OR TOWN Washington   | COUNTY | STATE D.C. |
| 24. FUNERAL DIRECTOR Donald V. Borgwardt  |  | 4400 Powder Mill Road<br>ADDRESS Beltsville, Md. 20705  | 25a. DATE REC'D. BY REGISTRAR NOV 05 1985  | 25b. REGISTRAR'S SIGNATURE <u>Ruth K. Johnson</u>   |        |            |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be submitted to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and returned to you, it may be filed in by the funeral director. page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper, place it over the original and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

20.11.16

— THE TWO ARE APPROPRIATE  
TO THIS  
IN WHICH WE COMMUNICATED

304183

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL. ITEM 1B SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. PAGE 4 SHOULD BE USED AS A BURIAL TRANSIT FORM. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PESTONIAN STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

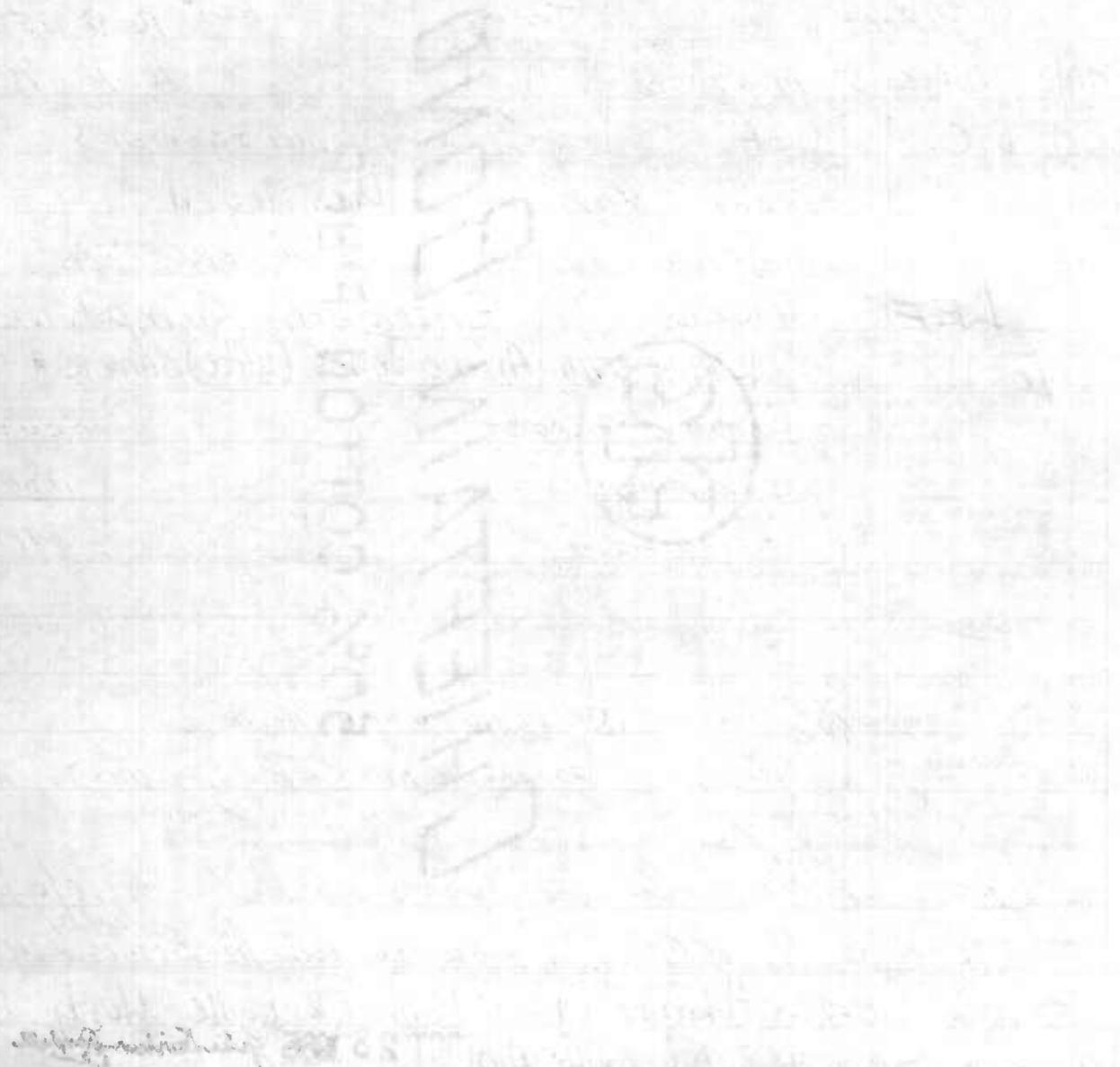
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

29015

|  |  |   |                                   |   |                    |                               |   |   |                          |                          |                                      |        |  |
|--|--|---|-----------------------------------|---|--------------------|-------------------------------|---|---|--------------------------|--------------------------|--------------------------------------|--------|--|
| 1- STATE REGISTRAR   |  |   |                                   |   |                    |                               | 2a. DATE KNOWN<br>OF ESTI.<br>DEATH MATED   |   |                          |                          | 2b. HOUR<br>MONTH DAY YEAR           |        |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT)   | FIRST  |   | MIDDLE                            |   | LAST               |                               | <input checked="" type="checkbox"/>   | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | 10 18 85                             | 0830 M |  |
| 3. SEX   | 4 RACE   | 5 DATE OF BIRTH<br>MONTH DAY YEAR             | 6 AGE (IN YEARS<br>LAST BIRTHDAY) | 7 IF UNDER 1 YR.  | 8 IF UNDER 24 HRS. |                               | 2c. DATE<br>PRONOUNCED<br>DEAD  | 2d. HOUR<br>MONTH DAY YEAR  |                          |                          |                                      |        |  |
| Male   | Black  | 5 19 37                                       | 48 yrs.                           | MONTHS DAYS   | HOURS MIN          |                               | 10 18 85  | 0830 M  |                          |                          |                                      |        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?   |   |                                   |   |                    |                               | 8. MARRIED  | NEVER MARRIED   | WIDOWED                  | DIVORCED                 | 9 BALTIMORE CITY OR COUNTY OF DEATH  |        |  |
| Wash. D.C.   | USA  |   |                                   |   |                    |                               | <input checked="" type="checkbox"/>   | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | Montgomery                           |        |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |                                   |   |                    |                               | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)                    |   |                          |                          | 12b. KIND OF BUSINESS<br>OR INDUSTRY |        |  |
| Bethesda   | Suburban Hospital  |   |                                   |   |                    |                               | Unemployed  |   |                          |                          | 20818                                |        |  |
| 13a. STATE   | 13b. COUNTY  | 13c. CITY OR TOWN                             |                                   |   |                    |                               |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                 | 13e. STREET ADDRESS      |                          |                                      |        |  |
| MD   | MONTGOMERY   | Crown Plaza                                   |                                   |   |                    |                               |   | 27 CARVER ROAD  |                          |                          |                                      |        |  |
| 14. FATHER'S NAME<br>FIRST   | MIDDLE   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST |                                   |   |                    |                               |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |                          |                          |                                      |        |  |
| Lee  | Jones  | Elizabeth Lumpkins                            |                                   |   |                    |                               |   | ACUTE   |                          |                          |                                      |        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  | 16b. SOCIAL SECURITY NO.   |   |                                   |   |                    |                               | 17. INFORMANT<br>ADDRESS  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) |                          |                          |                                      |        |  |
| No   | 519-46-3714  |   |                                   |   |                    |                               | Arlene Jones (wife) SAME AS # 13  | CARDIAC ARREST<br>DUE TO, OR AS A CONSEQUENCE OF  |                          |                          |                                      |        |  |
| Conditions, if any, which give rise to immediate cause (a) stating the underlying cause lost.  |  |   |                                   |   |                    |                               |   |   |                          |                          |                                      |        |  |
| (b) CARDIOMYOPATHY<br>DUE TO, OR AS A CONSEQUENCE OF   |  |   |                                   |   |                    |                               |   |   |                          |                          |                                      |        |  |
| (c) ETHANOLISM<br>YRS.   |  |   |                                   |   |                    |                               |   |   |                          |                          |                                      |        |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).   |  |   |                                   |   |                    |                               |   |   |                          |                          |                                      |        |  |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |                                   |   |                    |                               | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |                          |                          |                                      |        |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR  |   |                                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |                    |                               |   |   |                          |                          |                                      |        |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>   | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)   |   |                                   | 21f. LOCATION<br>STREET<br>27 Carver Rd                                       |                    |                               | CITY OR TOWN<br>Crown Plaza   | COUNTY<br>Mont.   | STATE<br>Md.             |                          |                                      |        |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |   |                                   |   |                    |                               |   |   |                          |                          |                                      |        |  |
| ACTUAL SIGNATURE <i>Francis C Mayo</i> TITLE (SPECIFY) M.D. DEPT MEDICAL EXAMINER  |  |   |                                   |   |                    |                               |   |   |                          |                          |                                      |        |  |
| DATE SIGNED 10/18/85<br>20814  |  |   |                                   |   |                    |                               |   |   |                          |                          |                                      |        |  |
| EXAMINER'S NAME (TYPE OR PRINT) Francis C Mayo ADDRESS Enclosed in an Envelope   |  |   |                                   |   |                    |                               |   |   |                          |                          |                                      |        |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 23b. DATE                                     |                                   | 23c. NAME OF CEMETERY OR CREMATORY  |                    | 23d. LOCATION<br>CITY OR TOWN |   | 23e. DATE OF DEATH BY CEMETERY OR CEMETERY  |                          |                          |                                      |        |  |
| Burial   |  | 10-22-85                                      |                                   | Lincoln Park Cem  |                    | Rockville Mont                |   | Md.   |                          |                          |                                      |        |  |
| 24. FUNERAL DIRECTOR<br>NAME   |  | ADDRESS                                       |                                   | 25. REGISTRAR'S SIGNATURE   |                    |                               |   |   |                          |                          |                                      |        |  |
| George R. Snowden  |  | Rockville, Md.                                |                                   | OCT 23 1985   |                    |                               |   |   |                          |                          |                                      |        |  |

841708



303075

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

85 29071

|  |  |   |             |  |             |   |                                   |   |  |          |          |      |  |
|--|--|---|-------------|--|-------------|---|-----------------------------------|---|--|----------|----------|------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   | FIRST EDGAR | MIDDLE LLOYD   | LAST JORDAN | 2a. DATE OF DEATH   | MONTH                             | DAY   | YEAR   | 2b. HOUR | 10 23 85 | 2P M |  |
| 3. SEX   |  | 4. RACE   |             | 5. DATE OF BIRTH   |             | 6. AGE (IN YEARS LAST BIRTHDAY)   |                                   |   | 7. IF UNDER 1 YEAR   |          |          |      |  |
| MALE   |  | WHITE   |             | MONTH SEPT. DAY 15, 1911 YEAR  |             | 74  |                                   |   | MONTHS DAYS  |          |          |      |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |             | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>  |             | 9. BALTIMORE CITY OR COUNTY OF DEATH  |                                   |   | MD.  |          |          |      |  |
| MASSACHUSETTS  |  | U.S.A.  |             | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |             | MONTGOMERY  |                                   |   |  |          |          |      |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN STATE, FACILITY, GIVE STREET ADDRESS) |             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |             |   | 12b. KIND OF BUSINESS OR INDUSTRY |   |  |          |          |      |  |
|  |  | POTOMAC VALLEY NURSING HOME   |             | SALES REP.   |             |   | CERAMICS                          |   |  |          |          |      |  |
| 13a. STATE<br>MARYLAND   |  | 13b. COUNTY<br>MONTGOMERY   |             | 13c. CITY OR TOWN<br>GAITHERSBURG  |             | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   | 13e. STREET ADDRESS / ZIP CODE<br>748 QUINCE ORCHARD BLVD.      |  | 20878    |          |      |  |
| 14. FATHER'S NAME<br>FIRST LESTER  |  | MIDDLE M.   |             | LAST JORDAN  |             | 15. MOTHER'S MAIDEN NAME<br>ALICE   |                                   | 16. APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>1 year - |  |          |          |      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>KOREAN   |             | 17. INFORMANT (DAUGHTER)<br>CHERYLL PROCTOR, 11812 HITCHING POST LANE,   |             | ADDRESS<br>ROCKVILLE, MD. 20852   |                                   |   |  |          |          |      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <i>Riskdney Tache</i>   |  |   |             |  |             |   |                                   |   |  |          |          |      |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Two Stage Abortion disease</i>  |  |   |             |  |             |   |                                   |   |  |          |          |      |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |   |             |  |             |   |                                   |   |  |          |          |      |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>disease</i>   |  |   |             |  |             |   |                                   |   |  |          |          |      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a   |  |   |             |  |             |   |                                   |   |  |          |          |      |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |             |  |             |   | 20a. AUTOPSY?                     |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |          |          |      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |             | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                             |                                   | YES <input type="checkbox"/> NO <input type="checkbox"/>        |  |          |          |      |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                      |             | 21f. LOCATION<br>STREET  |             | CITY OR TOWN  |                                   | COUNTY  |  | STATE    |          |      |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1980 19 to 10/23 19 85, that (II) (we) last saw the deceased alive on 10/15/85 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |             |  |             |   |                                   |   |  |          |          |      |  |
| 22b. SIGNATURE<br><i>Robert Hickey</i>   |  | 22c. DEGREE   |             | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |             | 22d. DATE SIGNED<br>10/23/85  |                                   |   |  |          |          |      |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>EDWARD J. MARTIN, M.D.  |  | 22e. ADDRESS<br>8008 Hidden Hill Ln - POTOMAC MD.   |             |  |             |   |                                   |   |  |          |          |      |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>CREMATION  |  | 23b. DATE<br>10/24/85   |             | 23c. NAME OF CEMETERY OR CREMATORIAL<br>METROPOLITAN CREMATORIAL   |             | 23d. LOCATION<br>CITY OR TOWN<br>ALEXANDRIA, VIRGINIA   |                                   | STATE   |  |          |          |      |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>1804 T ST., N.W., WASHINGTON, D.C. 20009   |  |   |             | 25a. DATE REC'D. BY REGISTRAR<br>OCT 28 1985   |             | 25b. REGISTRAR'S SIGNATURE<br><i>John Martin, Jr.</i>   |                                   |   |  |          |          |      |  |

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be secured within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the physician, it should be detached for use as the burial-transit permit. Then please remove this page and file with the State Dept. of Health and Mental Hygiene prior to burial. Cremation IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trouble



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

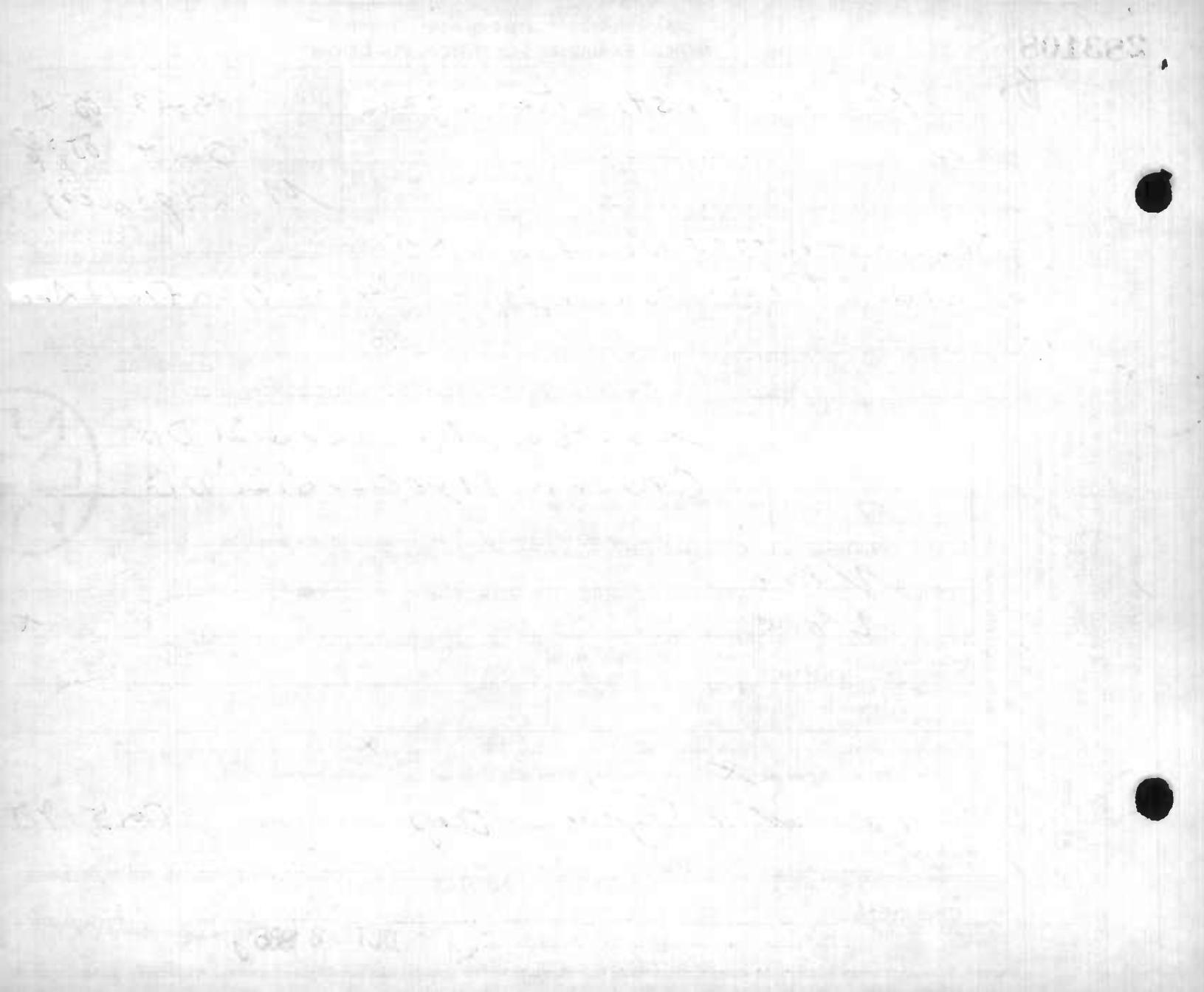
| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |  |  |  |  |  |  |  |  | 85 29078  |  |  |                              |  |  |
|---|--|--|---|--|--|--|--|--|--|--|--|---|--|--|------------------------------|--|--|
|   |  |  |   |  |  |  |  |  |  |  |  | REG. NO.  |  |  |                              |  |  |
| 1 - FOR STATE REGISTRAR   |  |  | I. DECEASED NAME<br>(TYPE OR PRINT)   |  |  | FIRST MIDDLE LAST  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |  | 2b. HOUR  |  |  |                              |  |  |
| 295103  |  |  | DEJAN (NMN) JOVANOVIĆ   |  |  |  |  |  | OCTOBER 14, 1985   |  |  | 1:30 P M  |  |  |                              |  |  |
| 3 SEX MALE  |  |  | 4 RACE WHITE  |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR   |  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>50 YRS.  |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |  |                              |  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Yugoslavia  |  |  | 7b CITIZEN OF WHAT COUNTRY?<br>USA  |  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY COUNTY MD.   |  |  |   |  |  |                              |  |  |
| 10 CITY OR TOWN OF DEATH<br>BETHESDA  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE CLINICAL CENTER, NIH |  |  | 12a USUAL OCCUPATION<br>TYPE OF WORK FOR MOST OF WORKING LIFE<br>Engineer  |  |  | 12b KIND OF BUSINESS OR INDUSTRY<br>Employed   |  |  |   |  |  |                              |  |  |
| 13a STATE MARYLAND  |  |  | 13b COUNTY Mont.  |  |  | 13c CITY OR TOWN SILVER SPRING   |  |  | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  | 13e STREET ADDRESS / ZIP CODE<br>1008 HOBBS DRIVE (20904)   |  |  |                              |  |  |
| 14 FATHER'S NAME<br>FIRST Yevram  |  |  | MIDDLE Jovanovic  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST Jelica   |  |  | MIDDLE   |  |  | LAST Jovanovic  |  |  |                              |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  |  |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>022-30-1425   |  |  | 17 INFORMANT (WIFE)<br>MRS. DIANA JOVANOVIĆ SAME AS ABOVE  |  |  | ADDRESS  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>15 min  |  |  |                              |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE 1a)  |  |  | Intra abdominal hemorrhage due to rupture of aorta near abdominal abscess   |  |  | 19. DUE TO, OR AS A CONSEQUENCE OF<br>(b) Liver necrosis Intra abdominal abscess secondary to ischemic damage  |  |  | 20. DUE TO, OR AS A CONSEQUENCE OF<br>(c) Status post multiple surgical procedures to treat adenocarcinoma of the stomach 6 months |  |  | 3 months  |  |  |                              |  |  |
| Conditions, if any, which gave rise to immediate cause 1a, stating the underlying cause lost.   |  |  |   |  |  |  |  |  |  |  |  |   |  |  |                              |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.  |  |  |   |  |  |  |  |  |  |  |  |   |  |  |                              |  |  |
| 21a. DATE OF OPERATION  |  |  | 21b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                     |  |  |                              |  |  |
| 21d. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  |  | 21e. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |   |  |  |                              |  |  |
| 21g. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  | 21h. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  | 21i. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |   |  |  |                              |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> this hospital attended the deceased from May 26, 1985, to October 14, 1985, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on October 14, 1985, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (not) view the body after death. |  |  |   |  |  |  |  |  |  |  |  |   |  |  |                              |  |  |
| 22b. SIGNATURE<br><i>Moshe M. H. D.</i>   |  |  |   |  |  |  |  |  |  |  |  | 22c. DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  | 22d. DATE SIGNED<br>10/15/85 |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Papa MOSHE ZVI H. D.   |  |  | 22e. ADDRESS NATIONAL INSTITUTES OF HEALTH<br>CLINICAL CENTER, BETHESDA, MARYLAND 20892   |  |  |  |  |  |  |  |  |   |  |  |                              |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>Cremation  |  |  | 23b. DATE<br>10/17/85   |  |  | 23c. NAME OF CEMETERY OR CREMATORIAL<br>Lee's Crematory  |  |  | 23d. LOCATION<br>Wash. D.C. COUNTY STATE   |  |  |   |  |  |                              |  |  |
| 24 FUNERAL DIRECTOR<br>Hines/Rinaldi 11800 New Hamp. Ave. S.S. Md.  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 18 1985  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Jeanne Anderson-Hendee</i>  |  |  |  |  |  |   |  |  |                              |  |  |
| DHMH - 16 60M 7/B4<br>(VRA 15, 4)   |  |  |   |  |  |  |  |  |  |  |  |   |  |  |                              |  |  |

001600

283108

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. AND 3 TO THE FUNERAL DIRECTOR.  
 PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.  
 TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 2 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |  |                                    |  |  | REG. NO. 852907   |                    |          |   |  |  |                                      |  |  |                       |  |  |  |  |  |
|--|--|--|--|--|--|---|--|--|------------------------------------|--|--|---|--------------------|----------|---|--|--|--------------------------------------|--|--|-----------------------|--|--|--|--|--|
| 1- STATE REGISTRAR   |  |  | 2a. DATE KNOWN <input type="checkbox"/> MONTH DAY YEAR   |  |  |   |  |  |                                    |  |  | 2b. HOUR  |                    |          |   |  |  |                                      |  |  |                       |  |  |  |  |  |
| 1c. DECEASED NAME<br>(TYPE OR PRINT)   |  |  | FIRST  |  |  | MIDDLE  |  |  | LAST                               |  |  | 2c. DATE OF ESTI-<br>DEATH MATED  | 2d. MONTH DAY YEAR | 2e. HOUR |   |  |  |                                      |  |  |                       |  |  |  |  |  |
| Robert H. Kanazawa   |  |  |  |  |  |   |  |  |                                    |  |  | Oct 3 1985  |                    | AM       |   |  |  |                                      |  |  |                       |  |  |  |  |  |
| 3. SEX   |  |  | 4. RACE  |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR  |  |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY |  |  | 7f. IF UNDER 1 YR. <input type="checkbox"/> UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN    |                    |          | 7c. DATE PRONOUNCED<br>DEAD   |  |  | 7d. MONTH DAY YEAR                   |  |  | 7e. HOUR              |  |  |  |  |  |
| Male   |  |  | Cauc.  |  |  | Nov. 17, 1916   |  |  | 68 yrs.                            |  |  |   |                    |          | Oct 4 1985 6:00 PM  |  |  |                                      |  |  |                       |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  |   |  |  |                                    |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |                    |          | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |  | County                |  |  |  |  |  |
| Washington   |  |  | United States  |  |  |   |  |  |                                    |  |  |   |                    |          |   |  |  | Montgomery                           |  |  | MD.                   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |   |  |  |                                    |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK)  |                    |          | 12b. KIND OF BUSINESS<br>FOR MOST OF WORKING LIFE                             |  |  | Ichthyologist                        |  |  | Smithsonian Institute |  |  |  |  |  |
| Kensington   |  |  | 4005 Denfeld Avenue  |  |  |   |  |  |                                    |  |  |   |                    |          |   |  |  |                                      |  |  |                       |  |  |  |  |  |
| 13a. STATE   |  |  | 13b. COUNTY  |  |  | 13c. CITY OR TOWN   |  |  | 13d. INSIDE CITY LIMITS?           |  |  | 13e. STREET ADDRESS   |                    |          | 13f. ADDRESS  |  |  | Same as #13                          |  |  |                       |  |  |  |  |  |
| Maryland   |  |  | Montgomery   |  |  | Kensington  |  |  | NO                                 |  |  | XX 4005 Denfeld Avenue/20895  |                    |          |   |  |  |                                      |  |  |                       |  |  |  |  |  |
| 14. FATHER'S NAME  |  |  | FIRST  |  |  | MIDDLE  |  |  | LAST                               |  |  | 15. MOTHER'S MAIDEN NAME  |                    |          | 16. ADDRESS   |  |  | Nishioka                             |  |  |                       |  |  |  |  |  |
| Kinmatsu   |  |  |  |  |  |   |  |  | Chiyoko                            |  |  |   |                    |          |   |  |  |                                      |  |  |                       |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |  |  | 16b. SOCIAL SECURITY NO.   |  |  |   |  |  |                                    |  |  | 17. INFORMANT   |                    |          | 18. APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                           |  |  |                                      |  |  |                       |  |  |  |  |  |
| Yes  |  |  | 537-01-1670  |  |  |   |  |  |                                    |  |  | David T. Kanazawa, Son,   |                    |          |   |  |  |                                      |  |  |                       |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:   |  |  |  |  |  |   |  |  |                                    |  |  |   |                    |          |   |  |  |                                      |  |  |                       |  |  |  |  |  |
| IMMEDIATE CAUSE (a) <i>Sante Myocardial Dis</i><br>DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |   |  |  |                                    |  |  |   |                    |          |   |  |  |                                      |  |  |                       |  |  |  |  |  |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a) stating the under-<br>lying cause last.<br>(b) <i>Chronic Myocardial Dis</i><br>DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |   |  |  |                                    |  |  |   |                    |          |   |  |  |                                      |  |  |                       |  |  |  |  |  |
| (c) _____  |  |  |  |  |  |   |  |  |                                    |  |  |   |                    |          |   |  |  |                                      |  |  |                       |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a  |  |  |  |  |  |   |  |  |                                    |  |  |   |                    |          |   |  |  |                                      |  |  |                       |  |  |  |  |  |
| None   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |   |  |  |                                    |  |  | 20. AUTOPSY?  |                    |          |   |  |  |                                      |  |  |                       |  |  |  |  |  |
| None   |  |  |  |  |  |   |  |  |                                    |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                   |                    |          |   |  |  |                                      |  |  |                       |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |  |                                    |  |  |   |                    |          |   |  |  |                                      |  |  |                       |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)   |  |  | 21f. LOCATION<br>STREET   |  |  | CITY OR TOWN                       |  |  | COUNTY  |                    |          | STATE   |  |  |                                      |  |  |                       |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on<br>death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>ACTUAL SIGNATURE <i>John S. Rogers</i> M.D. TITLE (SPECIFY) M.D. Dep. MEDICAL EXAMINER |  |  |  |  |  |   |  |  |                                    |  |  |   |                    |          |   |  |  |                                      |  |  |                       |  |  |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |  |  | John S. Rogers, M.D.   |  |  |   |  |  |                                    |  |  | ADDRESS   |                    |          | DATE SIGNED 08/15/1985  |  |  |                                      |  |  |                       |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  |  | 23b. DATE  |  |  | 23c. NAME OF CEMETERY OR CREMATORIAL  |  |  | 23d. LOCATION<br>CITY OR TOWN      |  |  | COUNTY  |                    |          | STATE   |  |  |                                      |  |  |                       |  |  |  |  |  |
| Cremation  |  |  | October 6, 1985  |  |  | Metropolitan Crematory  |  |  | Alexandria                         |  |  | Virginia  |                    |          |   |  |  |                                      |  |  |                       |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME   |  |  | Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland   |  |  |   |  |  |                                    |  |  | 25a. DATE NOT BY REGIS  |                    |          | 25b. REGISTRATION SIGNATURE   |  |  |                                      |  |  |                       |  |  |  |  |  |
|  |  |  |  |  |  |   |  |  |                                    |  |  | Oct 8 1985  |                    |          |   |  |  |                                      |  |  |                       |  |  |  |  |  |
| DHMH - 17<br>(VR A15 ME (S))   |  |  |  |  |  |   |  |  |                                    |  |  |   |                    |          |   |  |  |                                      |  |  |                       |  |  |  |  |  |



282097

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 3 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |        |   |  |                   |   |   |                 |  |                    | 85 29080   |       |                                   |  |
|--|--|---|--------|---|--|-------------------|---|---|-----------------|--|--------------------|--|-------|-----------------------------------|--|
|  |  |   |        |   |  |                   |   |   |                 |  |                    | REG. NO.   |       |                                   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   | FIRST  | MIDDLE  | LAST   | 2a. DATE OF DEATH |   |   | MONTH           | DAY  | YEAR               | 2b. HOUR   |       |                                   |  |
| Olga   |  |   | C.     |   | Kania  | October 3, 1985   |   |   |                 |  |                    | 3:55 PM  |       |                                   |  |
| 3. SEX   |  | 4. RACE   |        | 5. DATE OF BIRTH  |  |                   | 6. AGE (IN YEARS LAST BIRTHDAY)   |   |                 | IF UNDER 1 YEAR                                    |                    | IF UNDER 24 HRS  |       |                                   |  |
| FEMALE   |  | CAUCASIAN   |        | SEPT 29, 1924   |  |                   | 61  |   |                 | YRS  | MONTHS             | DAYS   | HOURS | MIN.                              |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |  |                   | 9. BALTIMORE CITY OR COUNTY OF DEATH  |   |                 | MD.  |                    |  |       |                                   |  |
| PENNNSYLVANIA  |  | U.S.A.  |        | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                    |  |                   | Montgomery County   |   |                 | APPLIED INDUSTRY                                   |                    |  |       |                                   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |        |   |  |                   |   |   |                 |  |                    | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |       | 12b. KIND OF BUSINESS<br>INDUSTRY |  |
| Silver Spring  |  | Holy Cross Hospital   |        |   |  |                   |   |   |                 |  |                    | CLERK/TYPEPIST   |       | PHYSICS LAB                       |  |
| USUAL RESIDENCE IF NURSING HOME OR OTHER INSTITUTION. GIVE RESIDENCE BEFORE ADMISSION  |  |   |        |   |  |                   |   |   |                 |  |                    | 13a. STREET ADDRESS / ZIP CODE                                   |       |                                   |  |
| 13a. STATE   |  | 13b. COUNTY   |        | 13c. CITY OR TOWN   |  |                   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |                 | 14116 GRAND PRE ROAD 20906                         |                    |  |       |                                   |  |
| MARYLAND   |  | MONTGOMERY  |        | STIVER SPRING   |  |                   | 15. MOTHER'S MAIDEN NAME  |   |                 | LAST   |                    |  |       |                                   |  |
| 14. FATHER'S NAME  |  | FIRST   | MIDDLE | LAST  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES OR NO UNKNOWN)                          |                   | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT   |  | ADDRESS            |  |       |                                   |  |
| STEVEN   |  | KRAFTER   |        |   | NO   |                   | 204-12-5022   |   | EDWARD E. KANIA |  | SAME AS 13 HUSBAND |  |       |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>septic shock</u>  |  |   |        |   |  |                   |   |   |                 |  |                    | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>2 days</u> |       |                                   |  |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause, lost.<br>(b) <u>peritonitis</u>   |  |   |        |   |  |                   |   |   |                 |  |                    | <u>2 days</u>  |       |                                   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>ischemic colitis</u>  |  |   |        |   |  |                   |   |   |                 |  |                    | <u>1 month</u>   |       |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a<br><u>chronic renal failure, diabetes mellitus, atherosclerosis</u>   |  |   |        |   |  |                   |   |   |                 |  |                    |  |       |                                   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |        |   | 20a. AUTOPSY?  |                   |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?   |                 |  |                    |  |       |                                   |  |
|  |  |   |        |   | <input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                   |   | <input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                 |  |                    |  |       |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING<br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |        |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)               |                   |   |   |                 |  |                    |  |       |                                   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |        |   | 21f. LOCATION<br>STREET  |                   |   | CITY OR TOWN  |                 | COUNTY   | STATE              |  |       |                                   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>June 19 87</u> to <u>Oct 3 19 85</u> , that <input checked="" type="checkbox"/> (we) last<br>saw the deceased alive on <u>Oct 3 19 85</u> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. <input type="checkbox"/> (I) we did not view the body after death. |  |   |        |   |  |                   |   |   |                 |  |                    |  |       |                                   |  |
| 22b. SIGNATURE<br><u>Mark S. Rosen MD</u>  |  |   |        |   | DEGREE   |                   |   | ATTENDING<br>PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> MEDICAL<br>STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |                 | 22c. DATE SIGNED<br><u>10/4/85</u>                 |                    |  |       |                                   |  |
| 22d. PHYSICIAN'S NAME<br>(TYPE OR PRINT)<br>Mark S. Rosen, MD  |  | 22e. ADDRESS<br><u>Silver Spring, MD</u>  |        |   |  |                   |   |   |                 |  |                    |  |       |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>CREMATION  |  | 23b. DATE<br>10/3/85  |        |   | 23c. NAME OF CEMETERY OR CREMATORIUM<br>METROPOLITAN CREMATORIUM                             |                   |   | 23d. LOCATION<br>CITY OR TOWN<br>ALEXANDRIA   |                 | COUNTY   | STATE<br>VIRGINIA  |  |       |                                   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>FRANCIS J. COLLINS, JR.<br>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901   |  |   |        |   |  |                   |   | 25a. DATE REC'D. BY REGISTRAR<br>OCT 7 1985   |                 | 25b. REGISTRAR'S SIGNATURE<br><u>Mark S. Rosen</u> |                    |  |       |                                   |  |



85 29881

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

291045

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |   |   |                                   |
|--|--|---|--|---|---|---|-----------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST<br><b>MINNIE</b>  | MIDDLE<br><b>KAPLAN</b>  | LAST  | 2a. DATE OF DEATH<br>MONTH<br><b>OCT 13 85</b>                      | DAY<br>YEAR   | 2b. HOUR<br><b>11 A.M.</b>        |
| 3. SEX<br><b>Female</b>  |  | RACE<br><b>White</b>  | S. DATE OF BIRTH<br>MONTH<br><b>4 12 02</b>  | YEAR  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>83</b>                         | IF UNDER 1 YEAR<br>MONTHS<br>YRS  | IF UNDER 24 HRS.<br>HOURS<br>MIN. |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>New Jersey</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <b>XXX</b><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b>           |   |                                   |
| 10. CITY OR TOWN OF DEATH<br><b>Rockville</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Hebrew Home of Greater Washington</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Clerk</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U. S. Gov't</b>   |                                   |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   |   |   |                                   |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Montgomery</b>  | 13c. CITY OR TOWN<br><b>Rockville</b>  | 13d. INSIDE CITY LIMITS?<br><b>YES XX</b>   | 13e. STREET ADDRESS / ZIP CODE<br><b>6121 Montrose Road 20853</b>   |   |                                   |
| 14. FATHER'S NAME<br>FIRST<br><b>Simon</b>   |  | MIDDLE<br><b>Kaplan</b>   | LAST   | 15. MOTHER'S MAIDEN NAME<br>FIRST<br><b>Rebecca</b>   | MIDDLE  | LAST<br><b>Bitterman</b>  |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>384-46-8166</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Edward Frager Rockville, Maryland 20853</b>  | 18. APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>5 MIN</b> |   |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b>  |  |   |  |   |   |   |                                   |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>PNEUMONITIS</b>   |  |   |  |   |   |   |                                   |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause lost   |  |   |  |   |   |   |                                   |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>VASCULAR DEMENTIA</b>   |  |   |  |   |   |   |                                   |
| 19. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a<br><b>DEGENERATIVE JOINT DISEASE</b>   |  |   |  |   |   |   |                                   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <b>XXX</b>         | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |   |   |   |                                   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)   |  | 21f. LOCATION<br>STREET   | CITY OR TOWN  | COUNTY  | STATE                             |
| 22a. I certify that I (this hospital) attended the deceased from <b>5/82 79</b> to <b>10/13 85</b> , that I (we) last<br>saw the deceased alive on <b>10/13 1985</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above. I (we) did not view the body after death. |  |   |  |   |   |   |                                   |
| 22b. SIGNATURE<br><b>Steven Lipson</b>   |  | 22c. DEGREE<br><b>MD</b>  |  | 22d. ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22e. DATE SIGNED<br><b>10/13/85</b>                                 |   |                                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>STEVEN LIPSON</b>  |  | 22e. ADDRESS<br><b>6121 MONROSE RD, ROCKVILLE</b>   |  |   |   |   |                                   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>10/15/1985</b>  | 23c. NAME OF CEMETERY OR CREMATORIAL<br><b>MOUNT LEBANON</b>   |   | 23d. LOCATION<br>CITY OR TOWN<br><b>ADELPHI,</b>                    | COUNTY<br><b>P. G.,</b>   | STATE<br><b>MARYLAND</b>          |
| 24. FUNERAL DIRECTOR<br><b>DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME<br/>232 CARROLL STREET, N. W., WASHINGTON, D. C.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 17 1985</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julie Lipson PDR</b>   |   |   |                                   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the attending physician or by the hospital or attending physician retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or by the hospital or attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon copy of permit and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_  
DHMH - 16 600 7/84  
(VRA 15, 4)



304171

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 29082

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |  |                                   |   |                                      |   |       |                     |          |
|---|--|---|--|--|-----------------------------------|---|--------------------------------------|---|-------|---------------------|----------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   |  | FIRST  | MIDDLE                            | LAST  | 2a. DATE OF DEATH                    | MONTH   | DAY   | YEAR                | 2b. HOUR |
| FELICIA   |  |   |  | KASSELL  |                                   |   | 10                                   | 19  | 85    | 9:03 M              |          |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH   |                                   |   | 6. AGE (IN YEARS LAST BIRTHDAY)      |   |       | 7. IF UNDER 1 YEAR  |          |
| <input checked="" type="checkbox"/> Female  |  | Caucasian   |  | Oct. 30, 1893  |                                   |   | 91                                   |   |       | MONTHS DAYS         |          |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>    |                                   |   | 9. BALTIMORE CITY OR COUNTY OF DEATH |   |       | 10. IF UNDER 24 HRS |          |
| Poland  |  | USA   |  |  |                                   |   | Montgomery                           |   |       | HOURS MIN.          |          |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |                                   |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY |   |       | MD.                 |          |
| Potomac Valley  |  | Potomac Valley Nursing Home   |  |  |                                   |   | Librarian-Library of Congress        |   |       |                     |          |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |  |                                   |   |                                      |   |       |                     |          |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Montgomery   |  | 13c. CITY OR TOWN<br>Bethesda,   |                                   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                      | 13e. STREET ADDRESS / ZIP CODE<br>6804 Granby Street              |       | 20817               |          |
| 14. FATHER'S NAME<br>FIRST  |  | MIDDLE  |  | LAST   | 15. MOTHER'S MAIDEN NAME<br>FIRST |   | MIDDLE                               |   | LAST  |                     |          |
| Jeremiah  |  |   |  | Borenstein   | Mala                              |   |                                      |   | Laski |                     |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES OR NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   |  | 17. INFORMANT  |                                   | ADDRESS   |                                      |   |       |                     |          |
| No  |  | N/A   |  | 106 24 9267  |                                   | Simon Kassell Same as #13   |                                      |   |       |                     |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u>   |  |   |  |  |                                   |   |                                      |   |       |                     |          |
| APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>5 days</u>  |  |   |  |  |                                   |   |                                      |   |       |                     |          |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause last.   |  | (b) <u>Cerebrovascular disease</u>  |  | DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |                                   | greater than 3 years  |                                      |   |       |                     |          |
|   |  | (b) <u>Cerebrovascular disease</u>  |  |  |                                   |   |                                      |   |       |                     |          |
|   |  | (c) _____   |  |  |                                   |   |                                      |   |       |                     |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>dementia</u>   |  |   |  |  |                                   |   |                                      |   |       |                     |          |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |                                   | 20a. AUTOPSY?   |                                      | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH? |       |                     |          |
|   |  |   |  |  |                                   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                             |                                      | YES <input type="checkbox"/> NO <input type="checkbox"/>          |       |                     |          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |                                   |   |                                      |   |       |                     |          |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET  |                                   | CITY OR TOWN  |                                      | COUNTY  |       | STATE               |          |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1984</u> , 19, to <u>OCT 19</u> , 19 <u>85</u> , that (I) (we) last<br>saw the deceased alive on <u>OCT 18</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) did (did not) view the body after death. |  |   |  |  |                                   |   |                                      |   |       |                     |          |
| 22b. SIGNATURE<br><u>Deborah B Goldberg</u>   |  | DEGREE<br><u>MD</u>   |  | ATTENDING<br>PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> MEDICAL<br>STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |                                   | 22c. DATE SIGNED<br><u>10/19/85</u>   |                                      |   |       |                     |          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Deborah B Goldberg MD</u>   |  | 22e. ADDRESS<br><u>1106 Spring St, Silver Spring Md.</u>  |  |  |                                   |   |                                      |   |       |                     |          |
| 23a. BURIAL, CREMATION, REMOVAL<br><u>Burial</u>  |  | 23b. DATE<br><u>10-21-85</u>  |  | 23c. NAME OF CEMETERY OR CREMATORIUM<br><u>King David Memorial Pk.</u>   |                                   | 23d. LOCATION<br>CITY OR TOWN<br><u>Falls Church, Va.</u>                                       |                                      | 23e. COUNTY   |       | STATE               |          |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>Ives-Pearson Funeral Homes</u>   |  |   |  |  |                                   | 25a. DATE REC'D. BY REGISTRAR   |                                      | 25b. REGISTRAR'S SIGNATURE<br><u>Juliann Pendleton</u>            |       |                     |          |
| ADDITIONAL<br>FALLS CHURCH, VA. 22046   |  |   |  |  |                                   |   |                                      |   |       |                     |          |
|   |  |   |  |  |                                   |   |                                      |   |       |                     |          |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/statement permit. Then place the two pages in one envelope. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, air either traumatic or medical, complete Item 21 and attach a medical certificate.

DHMH - 16 60M 7/B4  
(VRA 15, 4)

171506



Duchess of Gloucester  
State Apartments



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be resubmitted by the hospital or attending physician.

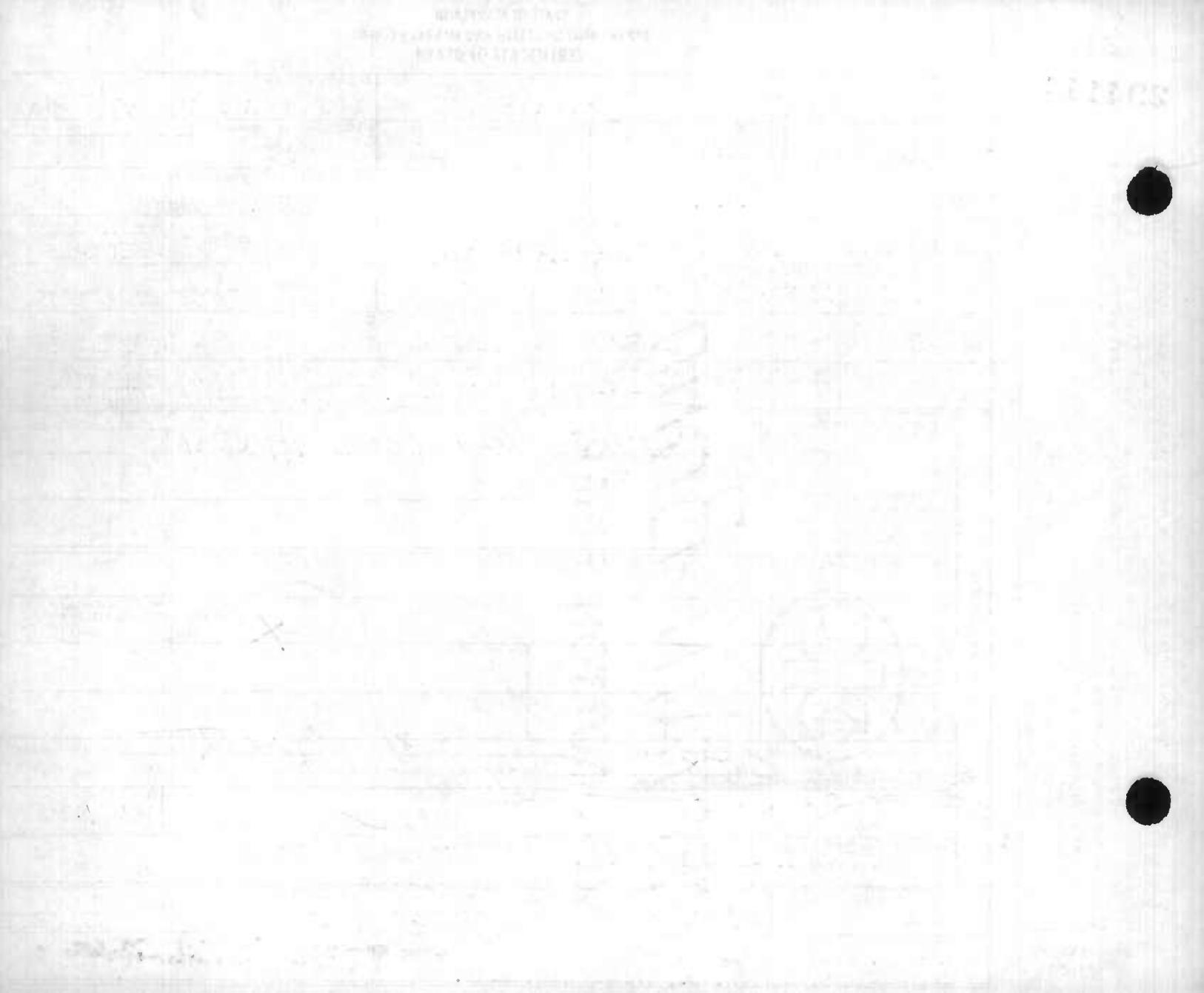
TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician, it should be delivered for use as the burial permit. Then please remove carbon copies. Pages 2 &amp; 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 2 is marked or if item 18 shows any injury, or other trauma, or if the medical examiner must be notified of one,

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |        |   | 8 5 29083                                    |   |   |       |   |     |   |          |  |  |
|---|--|--|--|--|--|--|--|--------|---|--|---|---|-------|---|-----|---|----------|--|--|
|   |  |  |  |  |  |  |  |        |   | REG. NO.                                     |   |   |       |   |     |   |          |  |  |
| 1 - FOR<br>STATE<br>REGISTRAR   |  |  | 1. DECEASED NAME<br>(TYPE OR PRINT)                                    |  |  | FIRST  |  | MIDDLE |   | LAST   |   | 2a. DATE OF DEATH                                     |       | MONTH   | DAY | YEAR  | 2b. HOUR |  |  |
|   |  |  | IKE  |  |  |  |  |        |   | KAUFMAN                                      |   | 10 10 85  |       |   |     |   | 8:31 AM  |  |  |
| 3. SEX  |  |  | 4. RACE  |  |  | 5. DATE OF BIRTH   |  |        | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  |   | IF UNDER 1 YEAR                                       |       | IF UNDER 24 HRS   |     |   |          |  |  |
| male  |  |  | WHITE  |  |  | MONTH DAY YEAR   |  |        | 98  |  |   | MONTHS DAYS   |       | HOURS MIN.  |     |   |          |  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN)  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  | 8  |  |        | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |   | YRS.  |       |   |     |   |          |  |  |
| ROMANIA   |  |  | U.S.A.   |  |  | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |        | MONTGOMERY COUNTY   |  |   | MD.   |       |   |     |   |          |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION                |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |        | 12b. BUSINESS OR<br>INDUSTRY  |  |   |   |       |   |     |   |          |  |  |
| SILVER SPRING   |  |  | FAIRLAND NURSING CENTER  |  |  | MERCHANT   |  |        | VEGETABLES  |  |   |   |       |   |     |   |          |  |  |
| 13a. STATE<br>MARYLAND  |  |  |  |  |  |  |  |        |   | 13b. COUNTY<br>MONTGOMERY                    |   | 13c. CITY OR TOWN<br>ROCKVILLE                        |       | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |     | 13e. STREET ADDRESS<br>6101 MONTROSE ROAD 20852 |          |  |  |
| 14. FATHER'S NAME<br>MORRIS   |  |  |  |  |  |  |  |        |   | 15. MOTHER'S MAIDEN NAME<br>DEBORAH          |   |   |       |   |     | LAST<br>(UNASCERTAINABL                         |          |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>NO (S. NO OR UNKNOWN)   |  |  | 16b. SOCIAL SECURITY NO.<br>072-05-4791                                |  |  | 17. INFORMANT<br>PHYLIS M. STARR, 11801 ROCKVILLE PIKE<br>ROCKVILLE, MARYLAND  |  |        | ADDRESS<br>APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH          |  |   |   |       |   |     |   |          |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a)  |  |  |  |  |  |  |  |        |   | CARDIO PULMONARY ARREST                      |   |   |       |   |     |   |          |  |  |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause last  |  |  |  |  |  |  |  |        |   | (b)  |   |   |       |   |     |   |          |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b)   |  |  |  |  |  |  |  |        |   |  |   |   |       |   |     |   |          |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |  |  |  |  |  |  |        |   |  |   |   |       |   |     |   |          |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |  |  |  |        |   |  |   |   |       |   |     |   |          |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  |  |  |        | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH? |   |       |   |     |   |          |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |        | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>          |   |       |   |     |   |          |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f. LOCATION<br>STREET  |  |        | CITY OR TOWN  |  | COUNTY  |   | STATE |   |     |   |          |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from<br>saw the deceased alive on Oct 8 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |        |   | 19 81 to Present, 19 19                      |   |   |       |   |     |   |          |  |  |
| 22b. DEGREE   |  |  |  |  |  |  |  |        |   | 22c. DATE SIGNED<br>10/10/1985               |   |   |       |   |     |   |          |  |  |
| ATTENDING<br>PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF<br>PHYSICIAN <input type="checkbox"/>  |  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DR. JOHN J. MERENDINO, M. D.  |  |  | 22e. ADDRESS<br>11620 KEMP MILL ROAD<br>SILVER SPRING, MARYLAND 20902  |  |        |   |  |   |   |       |   |     |   |          |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>BURIAL   |  |  | 23b. DATE<br>10/11/1985  |  |  | 23c. NAME OF CEMETERY OR CREMATORIUM<br>CEDAR PARK CEMETERY  |  |        | 23d. LOCATION<br>CITY OR TOWN<br>WESTWOOD                           |  |   | COUNTY  |       | STATE<br>NEW JERSE  |     |   |          |  |  |
| 24. FUNERAL DIRECTOR<br>DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME<br>232 CARROLL STREET, N. W., WASHINGTON, D. C.  |  |  |  |  |  |  |  |        |   | 25a. DATE REC'D. BY REGISTRAR<br>TCT T4 1985 |   | 25b. REGISTRAR'S SIGNATURE<br>John J. Merendino, M.D. |       |   |     |   |          |  |  |

12705



282108

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be surrendered within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Page 2 will be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked on Item 18, then any injury, or other traumatic event, the medical cause of death must be listed.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 29084

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|  |  |   |                  |  |  |   |  |                                |        |                 |       |
|--|--|---|------------------|--|--|---|--|--------------------------------|--------|-----------------|-------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   | FIRST            | MIDDLE   | LAST   | 2a. DATE OF DEATH   | MONTH  | DAY                            | YEAR   | 2b. HOUR        |       |
| Richard John KAUFFMAN  |  |   |                  |  |  | 10/3/85   |  |                                |        | 4:10 AM         |       |
| 3. SEX   |  | 4 RACE  | 5. DATE OF BIRTH |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  | IF UNDER 1 YEAR                |        | IF UNDER 24 HRS |       |
| MALE   |  | WHITE   | MONTH            | DAY  | YEAR   | 74  | YRS  | MONTHS                         | DAYS   | HOURS           | MIN.  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |                  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH  |                                |        |                 |       |
| Pennsylvania   |  | USA   |                  |  |  |   | Montgomery   |                                |        |                 |       |
| 10 CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY   |                                |        |                 |       |
| Rockville  |  | 4605 HALLET PLACE   |                  |  | CONTRACTOR   |   | PAINTING   |                                |        |                 |       |
| 13a. STATE   |  | 13b. COUNTY   |                  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE |        |                 |       |
| Maryland   |  | Montgomery  |                  | Rockville  |  |   |  | 4605 HALLET PLACE / 20853      |        |                 |       |
| 14. FATHER'S NAME<br>FIRST   |  | MIDDLE  |                  | LAST   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST   |  | MIDDLE                         |        | LAST            |       |
| ABRAHAM  |  | -   |                  | KAUFFMAN   |  | MINNIE  |  | -                              |        | CLEMMONS        |       |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.  |                  |  | 17. INFORMANT  |   | ADDRESS  |                                |        |                 |       |
| NO   |  | NONE  |                  |  | 196-10-0705  |   | RUTH KAUFFMAN (WIFE) SAME AS #13.  |                                |        |                 |       |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a)   |  | 19. DUE TO, OR AS A CONSEQUENCE OF:<br>(b)  |                  |  | 20. APPROXIMATE INTERVAL<br>BETWEEN DEATH AND DEATH  |   |  |                                |        |                 |       |
|  |  | 1/84  |                  |  | 10/3/85  |   |  |                                |        |                 |       |
|  |  | 1/84  |                  |  | 1/84   |   |  |                                |        |                 |       |
|  |  | 1/84  |                  |  | 1/84   |   |  |                                |        |                 |       |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>OMS  |  |   |                  |  |  |   |  |                                |        |                 |       |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                  |  | 20a. AUTOPSY?  |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                |        |                 |       |
| -  |  | -   |                  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                |        |                 |       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |                                |        |                 |       |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |                  |  | 21f. LOCATION<br>STREET  |   | CITY OR TOWN   |                                | COUNTY |                 | STATE |
| 22a. I certify that (I) (this hospital) attended the deceased from<br>saw the deceased alive on 7/24 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) did not view the body after death. |  | 22b. SIGNATURE<br>Lester Johnson  |                  |  | DEGREE   |   | 22c. DATE SIGNED<br>10/3/85  |                                |        |                 |       |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Harry Scovensbord   |  | 22e. ADDRESS<br>1811 Prince Philip Dr., Olney, Md   |                  |  |  |   |  |                                |        |                 |       |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 23b. DATE<br>OCT. 4, 1985   |                  | 23c. NAME OF CEMETERY OR CREMATORIAL<br>CHAMBERS CREMATORY |  | 23d. LOCATION<br>CITY OR TOWN<br>RIVERDALE, PG CO., Maryland                                    |  | COUNTY                         |        | STATE           |       |
| 24. FUNERAL DIRECTOR<br>NAME<br>CHAMBERS Funeral Home  |  | ADDRESS<br>Silver Spring, Md.   |                  |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 7 1985  |   | 25b. REGISTRAR'S SIGNATURE<br>John Scovensbord   |                                |        |                 |       |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/trust permit. Then please remove this paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified or one of the following forms must be completed and filed with the State Dept. of Health and Mental Hygiene prior to burial:

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |        |      |   |  |  |  | 8 5 29085 |      |  |      |                  |      |
|--|--|--|---|--------|------|---|--|--|--|-----------|------|--|------|------------------|------|
|  |  |  |   |        |      |   |  |  |  | REG. NO.  |      |  |      |                  |      |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  | FIRST   | MIDDLE | LAST | 2a. DATE OF DEATH   |  |  | MONTH  | DAY       | YEAR | 2b. HOUR                                     |      |                  |      |
| Delores Mabel Keith  |  |  |   |        |      | October 17, 1985  |  |  |  |           |      | 5 A.M.                                       |      |                  |      |
| 3. SEX   |  |  | 4. RACE   |        |      | 5. DATE OF BIRTH  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |           |      | IF UNDER 1 YEAR                              |      | IF UNDER 24 HRS. |      |
| Female   |  |  | Black   |        |      | Jan. 12, 1927   |  |  | 58   |           |      | MONTHS                                       | DAYS | HOURS            | MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |  | 7b. CITIZEN OF WHAT COUNTRY?  |        |      | 8   |  |  | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |           |      | 9. BALTIMORE CITY OR COUNTY OF DEATH         |      |                  |      |
| Wash. D.C.   |  |  | USA   |        |      |   |  |  |  |           |      | MONTGOMERY                                   |      |                  |      |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |        |      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |           |      |  |      |                  |      |
| Bethesda   |  |  | Suburban Hospital   |        |      | Recreation Sup  |  |  | Montg. Co.   |           |      |  |      |                  |      |
| 13a. STATE   |  |  | 13b. COUNTY   |        |      | 13c. CITY OR TOWN   |  |  | 13d. INSIDE CITY LIMITS?   |           |      | 13e. STREET ADDRESS                          |      |                  |      |
| MD   |  |  | Montg.  |        |      | Kensington  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |           |      | 4002 Hampden St./ 20895                      |      |                  |      |
| 14. FATHER'S NAME  |  |  | FIRST MIDDLE LAST   |        |      | 15. MOTHER'S MAIDEN NAME  |  |  |  |           |      |  |      |                  |      |
| Wilbert Russell  |  |  |   |        |      | Mabel Jackson   |  |  |  |           |      |  |      |                  |      |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |  | 16b. SOCIAL SECURITY NO.  |        |      | 17. INFORMANT   |  |  | ADDRESS  |           |      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |      |                  |      |
| No   |  |  | 220-32-6261   |        |      | Patrick Keith (Grandson) same AS #13  |  |  |  |           |      | 2 Days                                       |      |                  |      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>STROKE</u><br>DOUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Hypertension</u><br>DOUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |  |   |        |      |   |  |  |  |           |      |  |      |                  |      |
| 15 yrs   |  |  |   |        |      |   |  |  |  |           |      |  |      |                  |      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).<br><u>Diabetes</u>   |  |  |   |        |      |   |  |  |  |           |      |  |      |                  |      |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |        |      | 20a. AUTOPSY?   |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?   |           |      |  |      |                  |      |
|  |  |  |   |        |      | YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |           |      |  |      |                  |      |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |        |      | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |           |      |  |      |                  |      |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |        |      | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |           |      |  |      |                  |      |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>man</u> 19 <u>75</u> to <u>SCT 17</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>10/12</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. |  |  |   |        |      |   |  |  |  |           |      |  |      |                  |      |
| 22b. SIGNATURE<br><u>Ronald L. Pollen</u>  |  |  | 22c. DEGREE<br><u>MD</u>  |        |      | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  | 22d. DATE SIGNED<br><u>10/17/85</u>  |           |      |  |      |                  |      |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>RICHARD H. POLLON MD</u>   |  |  | 22e. ADDRESS<br><u>10420 Greenway Ave, KENSINGTON MD</u>  |        |      |   |  |  |  |           |      |  |      |                  |      |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |  | 23b. DATE<br>10-23-85   |        |      | 23c. NAME OF CEMETERY OR CREMATORIAL<br>Mutual Mem. Cem   |  |  | 23d. LOCATION<br>CITY OR TOWN<br>Sandy Spring, Montg., MD  |           |      | 23e. DATE REC'D. BY REGISTRAR<br>OCT 23 1985 |      |                  |      |
| 24. FUNERAL DIRECTOR<br><u>George R. Snowden, Rockville, MD 20850</u>  |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Julia L. Wilson, Pollen</u>  |        |      |   |  |  |  |           |      |  |      |                  |      |

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**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PEN IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL TRANSFER TIN. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION OR REMOVAL.

**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

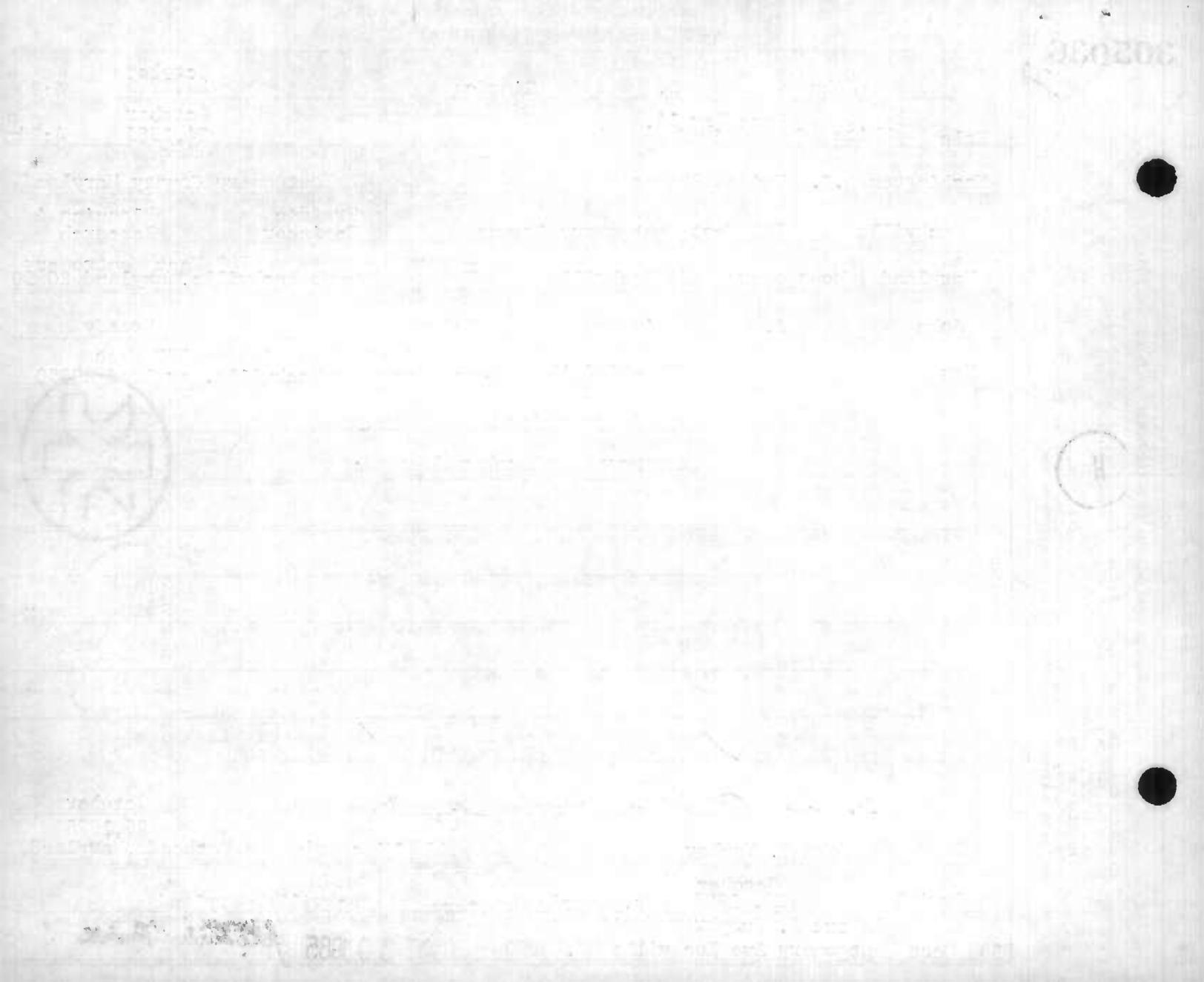
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**1 - FOR  
STATE  
REGISTRAR**

REG. NO.

|  |         |  |   |                          |   |   |                                |  |              |           |                     |
|--|---------|--|---|--------------------------|---|---|--------------------------------|--|--------------|-----------|---------------------|
| I. DECEASED NAME<br>(TYPE OR PRINT)  |         |  | FIRST   | MIDDLE                   | LAST  | 2a. DATE KNOWN<br>OF<br>DEATH MATED   | MONTH                          | DAY  | YEAR         | 2b. HOUR  |                     |
| John D. Kingdon  |         |  |   |                          |   | <input type="checkbox"/> October  | 24, 1985                       | 19   | 4:00 P.M.    |           |                     |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   | 6. AGE (IN YEARS<br>LAST BIRTHDAY)                          | IF UNDER 1 YR.<br>MONTHS | IF UNDER 24 HRS.<br>DAYS  | MIN   | 2c. DATE<br>PRONOUNCED<br>DEAD |  |              | 2d. HOUR  |                     |
| Male   | White   | December 14, 1938  | 46 yrs.   |                          |   |   | October 24, 1985               |  |              | 4:00 P.M. |                     |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |   |                          | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |                                | 9. BALTIMORE CITY OR COUNTY OF DEATH         |              |           |                     |
| Washington D.C.  |         | United States  |   |                          |   |   |                                | Montgomery County Maryland                   |              |           |                     |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |                          | 12a. USUAL OCCUPATION (TYPE OF WORK)<br>Traffic Engineer  |   |                                | 12b. KIND OF BUSINESS<br>Planning & Research |              |           |                     |
| Rockville  |         | 702 West Montgomery Avenue   |   |                          |   |   |                                |  |              |           |                     |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |         |  |   |                          |   | 13a. STATE<br>Maryland 13b. COUNTY<br>Montgomery 13c. CITY OR TOWN<br>Rockville 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS<br>702 West Montgomery Avenue Rockville, Maryland 20850 |                                |  |              |           |                     |
| 14. FATHER'S NAME<br>FIRST<br>John   |         |  | MIDDLE<br>A.  | LAST<br>Kingdon          | 15. MOTHER'S MAIDEN NAME<br>FIRST<br>Helen  |   |                                | MIDDLE<br>LAST<br>Bready                     |              |           |                     |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <input type="checkbox"/> YES   |         |  | 16b. SOCIAL SECURITY NO.<br>1957-1960                       |                          |   | 17. INFORMANT<br>Sarah Jane Kingdon 702 West<br>Montgomery Ave Rockville, Maryland 20850  |                                |  | ADDRESS      |           |                     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardio-respiratory Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a) stating the <u>underlying cause lost</u> .<br>(b) <u>Coronary Arteriosclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |         |  |   |                          |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |                                |  |              |           |                     |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |         |  |   |                          |   |   |                                |  |              |           |                     |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |                          |   |   |                                |  | 20. AUTOPSY? |           |                     |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   |                          | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |                                |  |              |           |                     |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |         | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)   |   |                          | 21f. LOCATION<br>STREET   |   | CITY OR TOWN                   |  | COUNTY       | STATE     |                     |
| 22a. I certify that I took charge of the remains described above, held on <u>Autopsy</u> <input type="checkbox"/> <u>Inspection</u> <input checked="" type="checkbox"/> <u>Inquiry</u> <input type="checkbox"/> and in my opinion<br>death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |         |  |   |                          |   |   |                                |  |              |           |                     |
| ACTUAL<br>SIGNATURE  |         | <u>John F. Tauber</u>  |   |                          | TITLE (SPECIFY)<br><u>M.D.</u>  |   |                                | MEDICAL EXAMINER                             |              |           | DATE<br>SIGNED      |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |         | John F. Tauber   |   |                          | ADDRESS   |   |                                | 8218 Wisconsin Ave Bethesda, Maryland        |              |           | October<br>25, 1985 |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |         | 23b. DATE<br>October<br>28, 1985   | 23c. NAME OF CEMETERY OR CREMATORIAL<br>St. Mary's Cemetery |                          |   | 23d. LOCATION<br>CITY OR TOWN<br>Rockville  |                                | COUNTY                                       |              | STATE     |                     |
| 24. FUNERAL DIRECTOR<br>NAME   |         | Robert A. Pumphrey Funeral Homes PA<br>300 West Montgomery Ave Rockville Md. 20850                         |   |                          | 25. DATE REC'D. BY REGISTRAR  |   |                                | 25. REGISTRAR'S SIGNATURE                    |              |           |                     |



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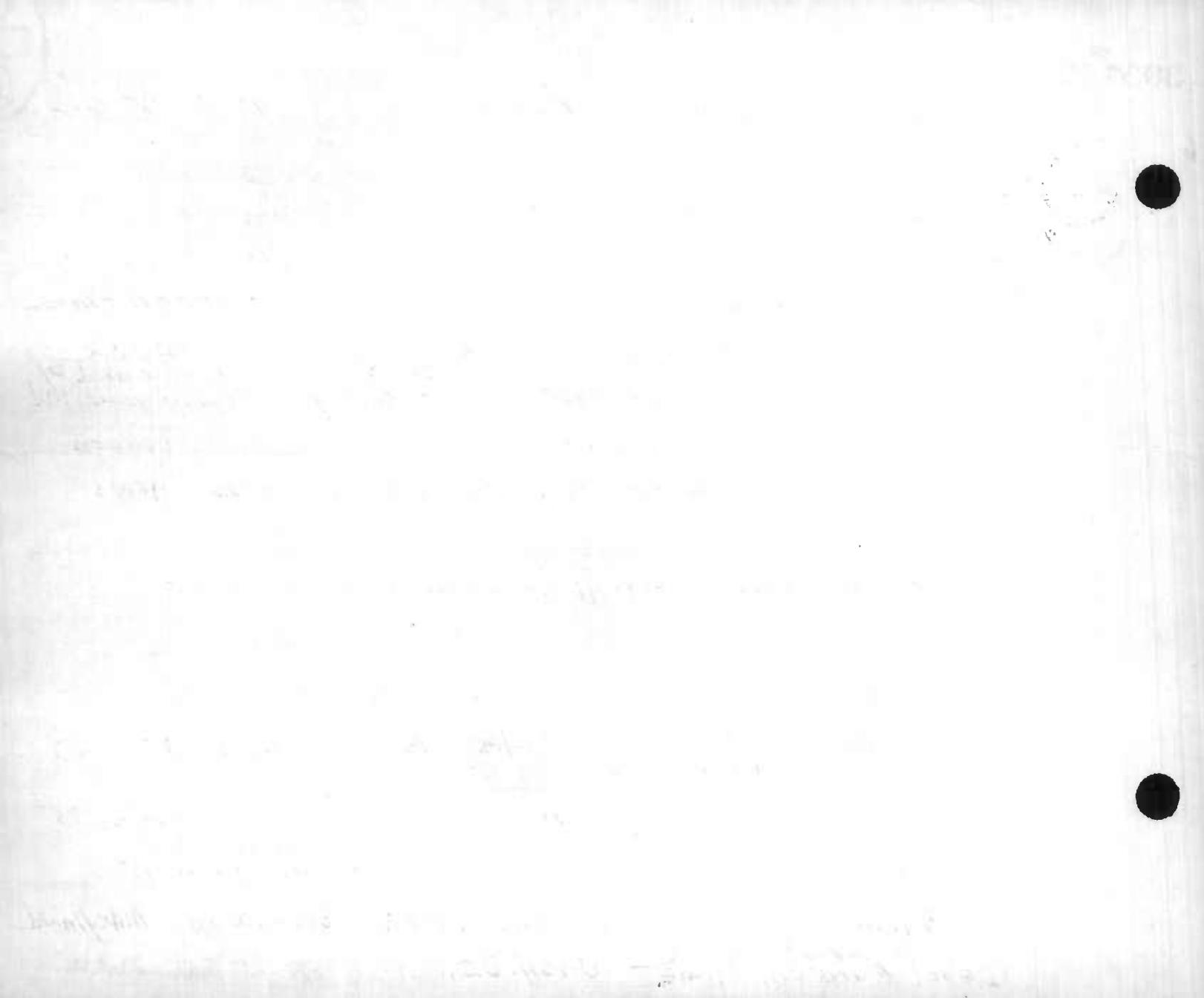
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, or by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be sent to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked (1) (we) saw any injury, or other traumatic event, the medical examiner must be informed.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   | REG. NO. 85 29087                |  |  |   |  |                           |  |  |  |
|---|--|--|--|---|----------------------------------|--|--|---|--|---------------------------|--|--|--|
| 1. DECEASED NAME FIRST MIDDLE LAST  |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR   |  |   |  |                           |  |  |  |
| WALTER L. KINSEY  |  |  |  |   | 10-23-85                         | 6 A.M.   |  |   |  |                           |  |  |  |
| 3. SEX Male   |  | 4. RACE W  |  | 5. DATE OF BIRTH MONTH DAY YEAR   |                                  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS           |  |  |  |
|   |  |  |  | 04 13 01  |                                  | 84   |  | MONTHS DAYS   |  | HOURS MIN.                |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA  |  | 7b. CITIZEN OF WHAT COUNTRY? USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                  | 9. BALTIMORE CITY OR COUNTY OF DEATH KENSINGTON MD   |  |   |  |                           |  |  |  |
| 10. CITY OR TOWN OF DEATH Kensington  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Circle House 20895 Carroll Pl. Kensington |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter   |                                  | 12b. KIND OF BUSINESS OR INDUSTRY 20895  |  |   |  |                           |  |  |  |
| 13. STATE Maryland  |  | 13b. COUNTY Montgomery   |  | 13c. CITY OR TOWN Kensington  |                                  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE 10231 CARROLL PLACE  |  |                           |  |  |  |
| 14. FATHER'S NAME FIRST William   |  | MIDDLE   |  | LAST KINSEY   |                                  | 15. MOTHER'S MAIDEN NAME ELZORIA   |  | MIDDLE  |  | LAST WEAVER               |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO  |  | 16b. SOCIAL SECURITY NO. 579184488   |  | 17. INFORMANT (SON) F. Gary Kinsey  |                                  | ADDRESS 11108 Lund Pl  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  | Kensington, Md 1 MONTH    |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) SEPTICEMIA<br><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) OBLITERATIVE PERIPHERAL ARTERIAL DISEASE YEARS<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br><br>(c)<br><br>DUE TO, OR AS A CONSEQUENCE OF |  |  |  |   |                                  |  |  |   |  |                           |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>CEREBROVASCULAR INSUFFICIENCY; CHRONIC OBSTRUCTIVE LUNG DISEASE  |  |  |  |   |                                  |  |  |   |  |                           |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |                                  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                           |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |                                  |  |  |   |  |                           |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET   |                                  | CITY OR TOWN   |  | COUNTY  |  | STATE                     |  |  |  |
| 22a. I certify that (1) this hospital attended the deceased from 10/12 19 82 to 10/23 19 85, that (1) we last saw the deceased alive on 10/23 19 85, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did not view the body after death.   |  |  |  |   |                                  |  |  |   |  |                           |  |  |  |
| 22b. SIGNATURE MARTIN C. SHARPE   |  | DEGREE M.D.  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/>   |                                  | MEDICAL DIRECTOR <input type="checkbox"/>  |  | STAFF PHYSICIAN <input type="checkbox"/>  |  | 22c. DATE SIGNED 10/23/85 |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARTIN C. SHARPE  |  | 22e. ADDRESS 3720 FARRAGUT AVE<br>KENNSINGTON, MD - 20895  |  |   |                                  |  |  |   |  |                           |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial  |  | 23b. DATE 10-26-85   |  | 23c. NAME OF CEMETERY OR CREMATORIUM FT. LINCOLN CEM.   |                                  | 23d. LOCATION CITY OR TOWN Brentwood   |  | COUNTY  |  | STATE Maryland            |  |  |  |
| 24 FUNERAL DIRECTOR NAME DEVol  |  | ADDRESS FUNERAL HOME   |  | 25a. DATE REC'D. BY REGISTRAR OCT 28 1985   |                                  | 25b. REGISTRAR'S SIGNATURE John Davidson, Randall  |  |   |  |                           |  |  |  |



304078

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 4-2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

85 29088

REG. NO.

1-  
STATE  
REGISTRAR

|   |  |   |                         |  |   |  |  |  |                                 |
|---|--|---|-------------------------|--|---|--|--|--|---------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST<br><i>Robert</i>  | MIDDLE<br><i>Edward</i> | LAST<br><i>Kiser</i>   | 2a. DATE KNOWN<br>OF<br>ESTI-<br>DEATH<br>MATED         | AD MONTH DAY YEAR<br><i>Oct 20 1985</i>                              | 2b. HOUR<br>220<br>2 M                               |  |                                 |
| 3. SEX<br><input checked="" type="checkbox"/>   | 4. RACE<br><input checked="" type="checkbox"/> | 5. DATE OF BIRTH<br>MONTH<br><i>Nov</i>   | DAY<br><i>Sept 12</i>   | YEAR<br><i>1939</i>  | 6. AGE (IN YEARS<br>LAST BIRTHDAY)<br>YRS.<br><i>46</i> | IF UNDER 1 YR.<br>MONTHS<br><input type="checkbox"/>                 | IF UNDER 24 HRS.<br>DAYS<br><input type="checkbox"/> | HOURS<br><input type="checkbox"/>                                | MIN<br><input type="checkbox"/> |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)<br><i>NORTH CAROLINA</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |                         | 8. MARRIED<br><input checked="" type="checkbox"/> NEVER MARRIED<br><input type="checkbox"/><br>WIDOWED<br><input type="checkbox"/><br>DIVORCED<br><input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Montgomery MD.</i>        |  |  |                                 |
| 10. CITY OR TOWN OF DEATH<br><i>Sil. Rd</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>3908 Littleton St.</i> |                         | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)<br><i>TECHNICIAN</i>  |   |  |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY<br><i>WASH GAS LIGHT CO</i> |                                 |
| 13a. STATE<br><i>MARYLAND</i>   | 13b. COUNTY<br><i>MONTGOMERY</i>               | 13c. CITY OR TOWN<br><i>SILVER SPRING</i>   |                         | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 13e. STREET ADDRESS<br><i>3908 Littleton St.</i>                     |  |  |                                 |
| 14. FATHER'S NAME<br>FIRST<br><i>CECIL</i>  |  | MIDDLE<br><i>LEWIS</i>  | LAST<br><i>KISER</i>    | 15. MOTHER'S MAIDEN NAME<br>FIRST<br><i>NAN</i>  |   | 16. APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><i>2 days</i> |  |  |                                 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><input checked="" type="checkbox"/> YES  |  | 16b. SOCIAL SECURITY NO.<br><i>1957-1961 246-50-2332</i>  |                         | 17. INFORMANT<br><i>NORMA KISER</i>  |   | ADDRESS<br><i>SAME AS 13 WIFE</i>                                    |  |  |                                 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Asphyxiation</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <i>Hanging</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |                         |  |   |  |  |  |                                 |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 - (a)<br><i>None</i>   |  |   |                         |  |   |  |  |  |                                 |
| 19a. DATE OF OPERATION<br><i>None</i>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |                         | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |  |  |  |                                 |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>10 10 AM Sept 19 1985</i>   |                         | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><i>Hanging</i>  |   |  |  |  |                                 |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)<br><i>Home</i>   |                         | 21f. LOCATION<br>STREET<br><i>Littleton St.</i>  |   | CITY OR TOWN<br><i>Silver Spring</i>                                 |  | COUNTY<br><i>Montgomery</i>                                      | STATE<br><i>MD</i>              |
| 22a. I certify that I took charge of the remains described above, held on<br>death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> , and in my opinion                    |  |   |                         |  |   |  |  |  |                                 |
| ACTUAL<br>SIGNATURE<br><i>John S. Rogers, Jr.</i>   |  |   |                         |  |   |  |  |  |                                 |
| EXAMINER'S NAME<br>(TYPE OR PRINT)  |  | JOHN S. ROGERS  |                         | TITLE (SPECIFY)<br><i>Medical Examiner</i>   |   | DATE<br><i>Oct 24 1985</i>   |  |  |                                 |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><input checked="" type="checkbox"/> BURIAL  |  | 23b. DATE<br><i>10/28/85</i>  |                         | 23c. NAME OF CEMETERY OR CREMATORIAL<br><i>SHARON MEMORIAL PARK</i>  |   | 23d. LOCATION<br>CITY OR TOWN<br><i>Charlotte</i>                    |  | COUNTY<br><i>Mecklenburg</i>                                     | STATE<br><i>N.C.</i>            |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>FRANCIS J. COLLINS, JR.</i>  |  | ADDRESS<br><i>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</i>   |                         | 25a. DATE REC'D. BY REGISTRAR<br><i>OCT 29 1985</i>  |   | 25b. SIGNATURE<br><i>John S. Rogers, Jr.</i>                         |  |  |                                 |



289093

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove carbon paper. If page 2 should be detached for use as the burial/transit permit. Then please remove carbon paper. If page 2 is marked or item 18 shows any injury, or other traumatic event, the medical certifying physician must be notified at once.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certifying physician must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |             |                             |   |        |   |   |   |   |   | REG. NO. 3529089   |                                   |                    |
|--|-------------|-----------------------------|---|--------|---|---|---|---|---|--|-----------------------------------|--------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |             |                             | FIRST   | MIDDLE | LAST  |   | 2a DATE OF DEATH  |   | MONTH   | DAY  | YEAR                              | 2b HOUR            |
| Frank  |             |                             | D.  |        | Kitts   |   | October 3, 1985   |   |   |  |                                   | 2-35p <sup>M</sup> |
| 3. SEX   | 4 RACE      |                             | 5. DATE OF BIRTH  |        |   | 6 AGE (IN YEARS LAST BIRTHDAY)  |   |   | 7 IF UNDER 1 YEAR   |  | 8 IF UNDER 1 MONTH                |                    |
| Male   | White       |                             | Oct. 11, 1901   |        |   | MONTH   | DAY   | YEAR  | MONTHS  | DAYS   | HOURS                             | MIN.               |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |             | 7b CITIZEN OF WHAT COUNTRY? |   |        | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |   | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH                               |  |                                   |                    |
| West Virginia  |             | USA                         |   |        |   |   |   |   | Montgomery County, MD.  |  |                                   |                    |
| 10. CITY OR TOWN OF DEATH  |             |                             | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |        |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)    |   |  | 12b. KIND OF BUSINESS OR INDUSTRY |                    |
| Olney  |             |                             | Montgomery General Hospital   |        |   |   |   | Laborer   |   |  | Vault Mfg.                        |                    |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |             |                             |   |        |   |   |   |   |   |  |                                   |                    |
| 13a. STATE   | 13b. COUNTY | 13c. CITY OR TOWN           | 13d. INSIDE CITY LIMITS?  |        |   | 13e. STREET ADDRESS / ZIP CODE  |   |   |   |  |                                   |                    |
| Maryland   | Montgomery  | Damascus                    | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |        |   | 24226 Town Spring Rd. 20872   |   |   |   |  |                                   |                    |
| 14. FATHER'S NAME  |             |                             | FIRST   | MIDDLE | LAST  | 15. MOTHER'S MAIDEN NAME  |   |   | LAST  |  |                                   |                    |
| David  |             |                             |   |        | Kitts   | Susan   |   |   | unknown   |  |                                   |                    |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES NO OR UNKNOWN)  |             |                             | 16b. SOCIAL SECURITY NO.  |        |   | 17. INFORMANT   |   |   | 18. ADDRESS   |  |                                   |                    |
| No   |             |                             | 234-01-5552   |        |   | Florence McVay, Gaithersburg, Md.   |   |   | 443 W. Diamond Ave.   |  |                                   |                    |
| APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH  |             |                             |   |        |   |   |   |   |   |  |                                   |                    |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cedopulmonary embolism</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Gave father &gt; anemia</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>Heart failure, blood栓塞</i> |             |                             |   |        |   |   |   |   |   |  |                                   |                    |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |             |                             |   |        |   |   |   |   |   |  |                                   |                    |
| 19a. DATE OF OPERATION   |             |                             | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |        |   |   |   | 20a. AUTOPSY?   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                                   |                    |
| -  |             |                             | -   |        |   |   |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                                   |                    |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |             |                             | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |        |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)   |   |   | 20c. DATE SIGNED<br>10/6/85                                       |  |                                   |                    |
| 21d. INJURY OCCURRED<br><br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |             |                             | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)                                     |        |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |   |  |                                   |                    |
| 22a. I certify that (I) (this Hospital) attended the deceased from 9/10/85 to 10/3, 1985, that (I) (we) last saw the deceased alive on 10/3, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did not view the body after death.          |             |                             |   |        |   |   |   |   |   |  |                                   |                    |
| 22b. SIGNATURE<br><i>Arthur Schoengold</i>   |             |                             | DEGREE<br><i>M.D.</i>   |        |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |   | 22c. DATE SIGNED<br>10/6/85                                       |  |                                   |                    |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |             |                             | 22e. ADDRESS  |        |   | 18111 Prince Philip Dr., Olney, Md.   |   |   |   |  |                                   |                    |
| Arthur Schoengold, M.D.  |             |                             |   |        |   |   |   |   |   |  |                                   |                    |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |             |                             | 23b. DATE   |        |   | 23c. NAME OF CEMETERY OR CREMATORIAL  |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY<br>Gassaway, Braxton, W. Va. |  |                                   |                    |
| Burial   |             |                             | Oct. 6, 1985  |        |   | Kitts   |   |   |   |  |                                   |                    |
| 24. FUNERAL DIRECTOR   |             |                             | 25a. DATE REC'D. BY REGISTRAR   |        |   | 25b. REGISTRAR'S SIGNATURE  |   |   |   |  |                                   |                    |
| Olin L. Molesworth, P.A., Damascus, Md.  |             |                             | Oct. 8, 1985  |        |   |   |   |   |   |  |                                   |                    |
| DHMH - 16 60M 7/84<br>(VRA 15, 4)  |             |                             |   |        |   |   |   |   |   |  |                                   |                    |

ECONOMY

150

• *Finalmente, el 20 de octubre de 1910*

Score = 7 - 14/15

Q

3

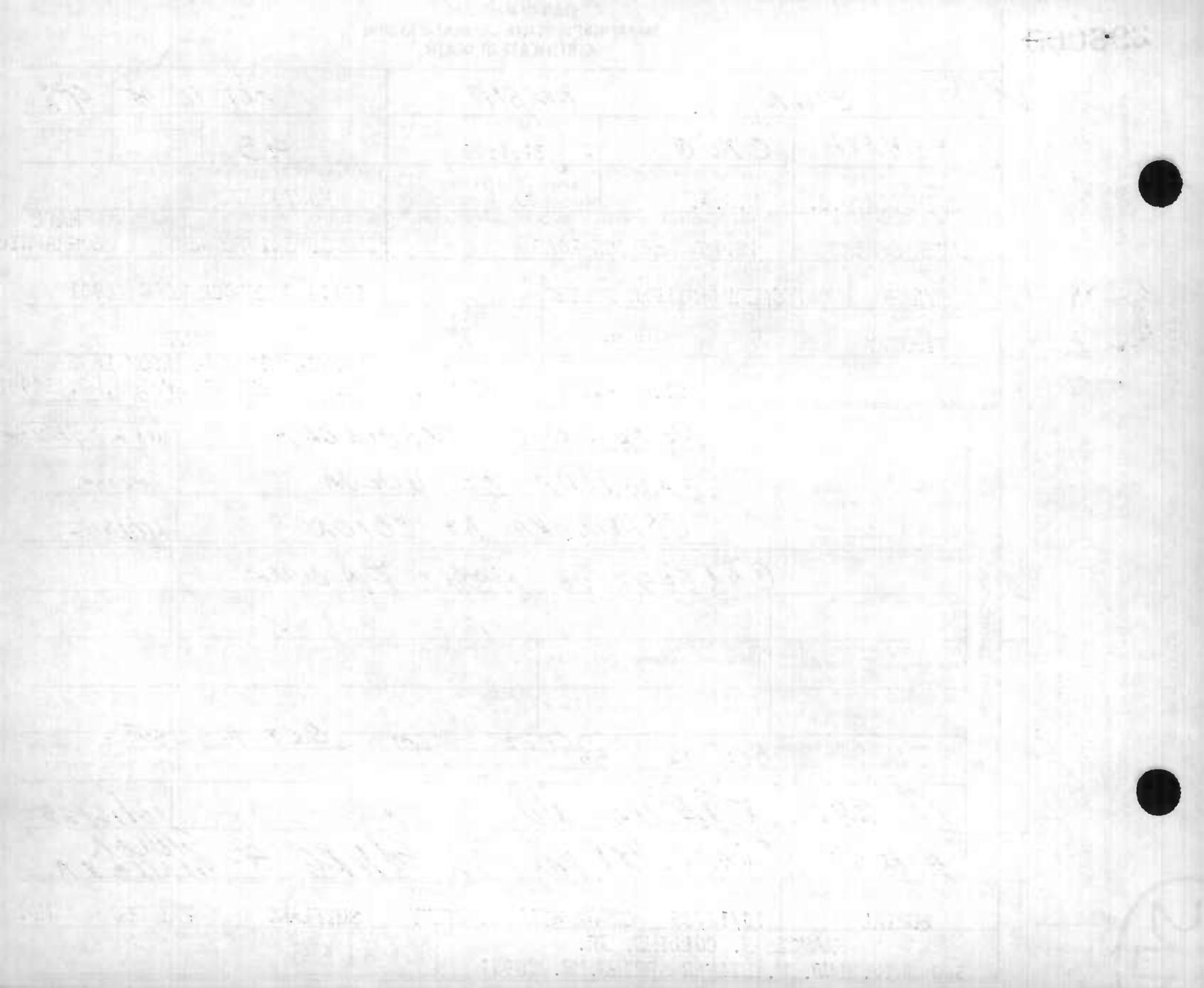
296003

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be presented within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |                     |                       |   |  |  |  | REG. NO. 85 29090 |  |   |  |  |
|--|--|--|--|---------------------|-----------------------|---|--|--|--|-------------------|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  | FIRST<br><i>ELLEN</i>  | MIDDLE<br><i>A.</i> | LAST<br><i>KNIGHT</i> | 2a. DATE OF DEATH<br>MONTH<br>YEAR  |  |  | 2b. HOUR<br>IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br>95 yrs  |                   |  |   |  |  |
| 3. SEX<br><b>FEWALE</b>  |  |  | 4. RACE<br><b>Cauc.</b>  |                     |                       | 5. DATE OF BIRTH<br>MONTH<br>AUG 31, 1890 DAY<br>YEAR   |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br>95 yrs                                     |                   |  |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>WASHINGTON, D.C.</b>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                     |                       | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b>  |                   |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>SILVER SPRING</b>  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>10116 GREENOCK ROAD</b>                      |                     |                       | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>FILE SUPERINTENDENT</b>  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>GEOGRAPHIC</b>   |                   |  |   |  |  |
| 13a. STATE<br><b>MARYLAND</b>  |  |  | 13b. COUNTY<br><b>MONTGOMERY</b>   |                     |                       | 13c. CITY OR TOWN<br><b>SILVER SPRING</b>   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                       |                   |  | 13e. STREET ADDRESS<br><b>10116 GREENOCK ROAD 20901</b> |  |  |
| 14. FATHER'S NAME<br>FIRST<br><b>TIMOTHY</b>   |  |  | MIDDLE<br><b></b>  |                     |                       | LAST<br><b>GANNON</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST<br><b>ANNIE</b>  |                   |  | MIDDLE<br><b>HUNTER</b>                                 |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>NO</b>   |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>579-48-8224</b>  |                     |                       | 17. INFORMATION<br>GRAND DAUGHTER ADDRESS<br><b>MARTHA E. HRONES</b>  |  |  | 17. INFORMATION<br>ADDRESS<br><b>1508 WHEATON LANE<br/>SILVER SPRING, MD. 20902</b>  |                   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>METASTATIC CARCINOVA.</b><br>DUE TO, OR AS A CONSEQUENCE OF.<br>(b) <b>CARCINOVA OF VULVA</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <b>CARCINOVA OF COLOR</b>     |  |  |  |                     |                       |   |  |  |  |                   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>WKS TO MONTHS</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a<br><b>CONGESTIVE HEART FAILURE</b>  |  |  |  |                     |                       |   |  |  |  |                   |  |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                     |                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                   |  |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |                     |                       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |                   |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |                     |                       | 21f. LOCATION<br>STREET<br>CITY OR TOWN<br>COUNTY<br>STATE  |  |  |  |                   |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>OCT 12</b> , 19 <b>79</b> , to <b>OCT 16</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>OCT 16</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |                     |                       |   |  |  |  |                   |  |   |  |  |
| 22b. SIGNATURE<br><i>Albert H. Grossman MD</i>   |  |  | 22c. DEGREE<br>ATTENDING MEDICAL STAFF<br>PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |                     |                       | 22d. DATE SIGNED<br><b>10/16/85</b>   |  |  |  |                   |  |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Albert H. Grossman MD</b>  |  |  | 22e. ADDRESS<br><b>1106 Shady St. Silver Spring</b>  |                     |                       |   |  |  |  |                   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  |  | 23b. DATE<br><b>10/18/85</b>   |                     |                       | 23c. NAME OF CEMETERY OR CREMATORIAL<br><b>CEDAR HILL CEMETERY</b>  |  |  | 23d. LOCATION<br>CITY OR TOWN<br><b>SUITLAND</b>   |                   |  | COUNTY<br><b>PRI GEO</b>                                |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>FRANCIS J. COLLINS, JR.</b>   |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 21 1985</b>  |                     |                       | 25b. REGISTRAR'S SIGNATURE<br><i>Francis J. Collins Jr.</i>   |  |  |  |                   |  |   |  |  |
| 500 UNTV. BLVD. W. SILVER SPRING, MD. 20901  |  |  |  |                     |                       |   |  |  |  |                   |  |   |  |  |



296153

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 29091

FOR  
STATE  
REGISTRAR

REG. NO.

|  |   |   |  |   |   |   |   |   |   |
|--|---|---|--|---|---|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |   |   | MIDDLE   | (LAST)  | 2. DATE OF DEATH                              | MONTH   | DAY   | YEAR  | 26 HOUR   |
| Jacob KOENIG   |   |   |  |   | 10/17/85                                      |   |   |   | 6 AM M  |
| 3. SEX   | RACE  | 5. DATE OF BIRTH  |  |   | 6. AGE (IN YEARS LAST BIRTHDAY)               | IF UNDER 1 YEAR<br>MONTHS DAYS  | IF UNDER 24 HRS<br>HOURS MIN.                                       |   |   |
| MALE   | Caucasian   | MONTH DAY YEAR<br>April 27, 1899  |  |   | 86 YRS  |   |   |   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH          |   |   |   |   |
| Austria  | USA   |   |  |   | Montgomery MD.                                |   |   |   |   |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)          |   |   |   |
| Silver Spring  | Holy Cross Hospital   |   |  |   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Remodelling Contractor-Self-employed |   |   |   |
| 13a. STATE   | 13b. COUNTY   | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |   |   | 13e. STREET ADDRESS / ZIP CODE<br>10000 Brunswick Ave. 20902              |   |   |   |
| Maryland   | Montgomery  | Silver Spring   |  |   |   |   |   |   |   |
| 14. FATHER'S NAME  | FIRST   | MIDDLE  | LAST   | 15. MOTHER'S MAIDEN NAME  |   |   | MIDDLE  | LAST  |   |
| Samuel   |   |   | Koenig   | Golda   |   |   |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   | 16b. SOCIAL SECURITY NO.  |   |  | 17. INFORMANT   |   |   | ADDRESS   |   |   |
| No   | N/A   |   |  | Edward Koenig   |   |   | 4319 Kentbury Drive<br>Bethesda, Md. 20814                          |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Respiratory arrest   |   |   |  |   |   |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) self-c�icnied hemorrhage   |   |   |  |   |   |   |   |   |   |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |   |   |  |   |   |   |   |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a   |   |   |  |   |   |   |   |   |   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |   |   | 20a. AUTOPSY?   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?   |   |
|  |   |   |  |   |   |   | <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |   |   |   |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM ETC.)  |  | 21f. LOCATION<br>STREET   |   |   | CITY OR TOWN  | COUNTY  | STATE   |
| 22a. I certify that I (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) <input checked="" type="checkbox"/> last<br>saw the deceased alive on Oct. 17, 1985, and that in my ( <input checked="" type="checkbox"/> ) opinion death occurred on the date and hour and from the causes stated<br>above. <input type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> not view the body after death. |   |   |  |   |   |   |   |   | 22c. DATE SIGNED<br>10-17-85                    |
| 22b. SIGNATURE<br><i>Jay Dein, MD</i>  |   | DEGREE  |  |   |   |   |   |   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Jay Dein, MD</i>   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  |   |   |   |   |   |   |
| 22e. ADDRESS   |   |   |  |   |   |   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |   | 23b. DATE<br>10-18-85   | 23c. NAME OF CEMETERY OR CREMATORIAL<br>King David Memorial Pk.                              |   |   | 23d. LOCATION<br>CITY OR TOWN<br>Falls Church, Va.                        |   |   | STATE   |
| 24. FUNERAL DIRECTOR<br>NAME   |   | Ives-Pearson Funeral Homes<br>Falls Church, Va. 22046   |  |   | 25a. DATE REC'D. BY REGISTRAR<br>Oct 21, 1985 |   | 25b. REGISTRAR'S SIGNATURE<br><i>Jay Dein, MD</i>                   |   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached from use on the burial permit. Then please remove this page. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 21 is marked, the medical examiner must be notified.

TO HOSPITAL OR ATTENDING PHYSICIAN: After this certificate has been signed by the attending physician, it should be detached from use on the burial permit. Then please remove this page. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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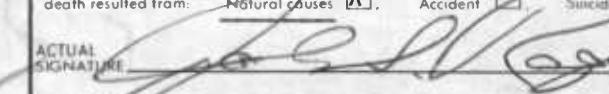
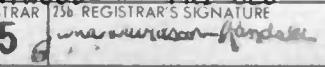
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANGELUS IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3 RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, Cremation, or Removal.

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29092

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |   |  |   |  |   |  |  |  |       |  |
|---|--|---|--|---|--|---|--|---|--|---|--|--|--|-------|--|
| 1- FOR<br>STATE<br>REGISTRAR  |  | LAST  |  |   |  |   |  |   |  |   |  | 2d. DATE KNOWN X MONTH DAY YEAR<br>OF ESTI-<br>DEATH MATED <input type="checkbox"/> 10/9 19 85 2:10<br>HOUR<br>P. M. |  |       |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST   |  | MIDDLE  |  | IF UNDER 1 YR.  |  | IF UNDER 24 HRS   |  | 2e. DATE PRONOUNCED<br>DEAD   |  | MONTH DAY YEAR<br>10/9 19 85 2:10<br>P. M.   |  |       |  |
| Laura   |  | May   |  | Koops   |  |   |  |   |  | 10/9 19 85  |  |  |  |       |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR  |  | 6. AGE (IN YEARS<br>LAST BIRTHDAY)  |  | 7. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED<br>WIDOWED X <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |       |  |
| Female  |  | White   |  | Dec. 27, 1902   |  | 82 yrs  |  | U.S.A.  |  |   |  | Montgomery County  |  |       |  |
| CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE ADDRESS) |  |   |  |   |  |   |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)   |  |       |  |
| Silver Spring   |  | 12004 New Hampshire Avenue  |  |   |  |   |  |   |  |   |  | HOUSEWIFE  |  |       |  |
| 13a. STATE  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS   |  | 20904   |  |  |  |       |  |
| Maryland  |  | Montgomery  |  | Silver Spring   |  | 12004 New Hampshire Avenue  |  |   |  |   |  |  |  |       |  |
| 14. FATHER'S NAME<br>FIRST  |  | MIDDLE  |  | LAST  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST   |  | MIDDLE  |  | LAST  |  |  |  |       |  |
| THOMAS  |  |   |  | WILLIAMS  |  | BERTHA  |  |   |  | JAMES   |  |  |  |       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)   |  | (IF YES, GIVE WAR OR DATES)   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT   |  | ADDRESS   |  |   |  |  |  |       |  |
| NO  |  |   |  | 220-58-6120   |  | ELMA MOLLOY   |  | SAME AS 13  |  | DAUGHTER  |  |  |  |       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:  |  |   |  |   |  |   |  |   |  |   |  |  |  |       |  |
| IMMEDIATE CAUSE (a) <u>Acute myocardial disease</u>   |  |   |  |   |  |   |  |   |  |   |  |  |  |       |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |   |  |   |  |   |  |   |  |  |  |       |  |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a) stating the <u>under-</u><br><u>lying cause last.</u>  |  |   |  |   |  |   |  |   |  |   |  |  |  |       |  |
| { (b) <u>chronic myocardial disease.</u>  |  |   |  |   |  |   |  |   |  |   |  |  |  |       |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |   |  |   |  |   |  |   |  |  |  |       |  |
| (c)   |  |   |  |   |  |   |  |   |  |   |  |  |  |       |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a   |  |   |  |   |  |   |  |   |  |   |  |  |  |       |  |
| None  |  |   |  |   |  |   |  |   |  |   |  |  |  |       |  |
| 19a. DATE OF OPERATION<br>None  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |  |   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                  |  |       |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  | 21b. TIME OF INJURY<br>P.M.   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>None |  | 19  |  | 21d. LOCATION<br>STREET   |  | CITY OR TOWN  |  | COUNTY   |  | STATE |  |
| 21e. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21f. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)                                      |  | 21g. LOCATION<br>STREET   |  | CITY OR TOWN  |  | COUNTY  |  | STATE   |  |  |  |       |  |
| 22a. I certify that I took charge of the remains described above, held an <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion<br>death resulted from: <input checked="" type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |   |  |   |  |   |  |   |  |  |  |       |  |
| ACTUAL SIGNATURE   |  |   |  |   |  |   |  |   |  |   |  |  |  |       |  |
| TITLE (SPECIFY)<br>Deputy MEDICAL EXAMINER  |  |   |  |   |  |   |  |   |  |   |  |  |  |       |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT) John S. Rogers, M.D.   |  |   |  |   |  |   |  |   |  |   |  |  |  |       |  |
| ADDRESS 1919 Seminary Road<br>Silver Spring, Montgomery County, Md.   |  |   |  |   |  |   |  |   |  |   |  |  |  |       |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE<br>10/12/85   |  | 23c. NAME OF CEMETERY OR CREMATORIAL<br>FT. LINCOLN CEMETERY                          |  | 23d. LOCATION<br>CITY OR TOWN<br>BRENTWOOD  |  | COUNTY  |  | STATE   |  |  |  |       |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>FRANCIS J. COLLINS, JR.<br>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT. 14 1985   |  | 25b. REGISTRAR'S SIGNATURE<br> |  | MD.   |  |  |  |       |  |
| BP  |  | DHMH - 17<br>(VR A15 ME (5))  |  |   |  |   |  |   |  |   |  |  |  |       |  |

11/12/19



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 5  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

29093

302036

**DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201**

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.

**PAGE 4:** SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR FILES.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION ON VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 prior to burial. PERMIT TO BURN OR REMOVAL

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

|  |           |                                    |   |                |                  |   |      |                |  |  |  |
|--|-----------|------------------------------------|---|----------------|------------------|---|------|----------------|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |           |                                    | MARY ROSE Kopp  |                |                  | 2a. DATE KNOWN OF ESTIMATED MATED   |      |                |  |  |  |
|  |           |                                    |   |                |                  | ✓ 10 18 19 85 A M   |      |                |  |  |  |
| 3. SEX   | 4. RACE   | 5. DATE OF BIRTH<br>MONTH DAY YEAR | 6. AGE (IN YEARS<br>LAST BIRTHDAY)  | IF UNDER 1 YR. | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD  |      |                |  |  |  |
| Female   | Caucasian | 09 04 02                           | 83 yrs.   | MONTHS         | DAYS             | HOURS   | MIN. | MONTH DAY YEAR |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New York  |           |                                    | 7b. CITIZEN OF WHAT COUNTRY?<br>United States   |                |                  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |      |                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY       |  |  |
| 10. CITY OR TOWN OF DEATH<br>ROCKVILLE   |           |                                    | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>15101 WESTBURY Rd |                |                  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)<br>Claims Clerk  |      |                | 12b. KIND OF BUSINESS<br>OR INDUSTRY US<br>Postal Serv   |  |  |
| 13a. STATE<br>MD   |           |                                    | 13b. COUNTY<br>MONTGOMERY   |                |                  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |      |                | 13e. STREET ADDRESS<br>15101 WESTBURY Rd                 |  |  |
| 14. FATHER'S NAME<br>FIRST<br>David  |           |                                    | 13c. CITY OR TOWN<br>Rockville  |                |                  | 15. MOTHER'S MAIDEN NAME<br>FIRST<br>Magdalena  |      |                | 20853  |  |  |
| MIDDLE   |           |                                    | LAST<br>Nold  |                |                  | MIDDLE  |      |                | LAST<br>Stritzl  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |           |                                    | 16b. SOCIAL SECURITY NO.<br>No 119 14 0945  |                |                  | 17. INFORMANT<br>Daughter Louise M. Whitt   |      |                | ADDRESS<br>Same as item 13                               |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> APPROXIMATE INTERVAL<br>DUE TO, OR AS A CONSEQUENCE OF <u>ACUTE</u><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. }<br>(b) <u>Arteriosclerotic Cardiovascular Disease</u> INDEF<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)               |           |                                    |   |                |                  |   |      |                |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><u>HYPERTENSIVE Cardiovascular Disease</u>  |           |                                    |   |                |                  |   |      |                |  |  |  |
| 19a. DATE OF OPERATION   |           |                                    | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |                |                  | 20. AUTOPSY?  |      |                |  |  |  |
|  |           |                                    |   |                |                  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |      |                |  |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |           |                                    | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 10 18 1985  |                |                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>Found Dead in Bed  |      |                |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE<br>AT WORK <input checked="" type="checkbox"/>  |           |                                    | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)<br>Home  |                |                  | 21f. LOCATION<br>STREET<br>15101 Westbury Rd<br>CITY OR TOWN<br>Rockville<br>COUNTY<br>Montgomery<br>STATE<br>Md  |      |                |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |           |                                    |   |                |                  |   |      |                |  |  |  |
| ACTUAL<br>SIGNATURE<br><u>Francis C. Mayle</u>   |           |                                    | TITLE (SPECIFY)<br>M.D. <u>Day</u>  |                |                  | MEDICAL EXAMINER  |      |                | DATE<br>SIGNED <u>10/19/85</u><br><u>20874</u>           |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Francis C. Mayle   |           |                                    | ADDRESS<br>8201 Wisconsin Avenue, Bethesda, MD  |                |                  |   |      |                |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Entombment   |           |                                    | 23b. DATE<br>Oct. 23, 1985  |                |                  | 23c. NAME OF CEMETERY OR CREMATORIAL<br>Gate of Heaven  |      |                | 23d. LOCATION<br>CITY OR TOWN<br>Silver Spring, Maryland |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>P.A., 300 West Montgomery Ave. Rockville, MD   |           |                                    | 24a. ADDRESS<br>ROBERT A. PUMPHREY FUNERAL HOMES, 125 1985  |                |                  | 24b. DATE REC'D. BY REGISTRAR   |      |                | 25b. REGISTRAR'S SIGNATURE<br><u>John Pendleton</u>      |  |  |

20250301

295013

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8529094

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |  |   |   |  |                      |                          |
|---|--|--|--|--|---|---|--|----------------------|--------------------------|
| I. DECEASED NAME<br>(TYPE OR PRINT)   |  |  |  | FIRST<br><b>SIMON</b>  | MIDDLE<br><b>E.</b>   | LAST<br><b>KROLL</b>  | 2a DATE OF DEATH<br><b>Oct. 6, 1985</b>  | MONTH<br>DAY<br>YEAR | 2b HOUR<br><b>1:58pm</b> |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH <b>06</b> DAY <b>13</b> YEAR <b>1884</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>101</b> YRS  |   | IF UNDER 1 YEAR<br>MONTHS<br>DAYS   | IF UNDER 24 HRS<br>HOURS<br>MIN.   |                      |                          |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Russia</b>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County MD.</b>   |   |   |  |                      |                          |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Suburban Hospital</b> |  |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Driver (Ret)</b> |   | 12b KIND OF BUSINESS OR INDUSTRY<br><b>Milk Company</b>  |                      |                          |
| 13a STATE<br><b>Maryland</b>  |  | 13b COUNTY<br><b>Montgomery</b>  | 13c CITY OR TOWN<br><b>Wheaton</b>   | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                     |   | 13e STREET ADDRESS / ZIP CODE<br><b>3507 Farthing Dr., Wheaton</b>                  |  | 20906 Md.            |                          |
| 14. FATHER'S NAME<br>FIRST<br><b>Barnard</b>  |  | MIDDLE<br><b></b>  | LAST<br><b>Kroll</b>   | 15. MOTHER'S MAIDEN NAME<br>FIRST<br><b>Etta</b>   |   | MIDDLE<br><b></b>   | LAST<br><b>Shulman</b>   |                      |                          |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b SOCIAL SECURITY NO.<br><b>102-07-1086</b>  |  | 17. INFORMANT<br><b>Bernard Kroll; 35-7 Farthing Drive</b>   |   | ADDRESS<br><b>Wheaton, Md., 20906</b>   |  |                      |                          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a))  |  | <i>Cardiac arrest</i>  |  |  |   |   |  |                      |                          |
|   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |   |   |  |                      |                          |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  | DUE TO, OR AS A CONSEQUENCE OF<br><i>congestive heart failure</i>  |  |  |   |   |  |                      |                          |
|   |  | DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____  |  |  |   |   |  |                      |                          |
|   |  | (c) _____  |  |  |   |   |  |                      |                          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |   |   |  |                      |                          |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |   | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                      |                          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |   |  |                      |                          |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f LOCATION<br>STREET   |   | CITY OR TOWN  | COUNTY   | STATE                |                          |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10-5 1985</b> , to <b>19</b> , that (I) (we) last saw the deceased alive on <b>10-5 1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (not) view the body after death. |  |  |  |  |   |   |  |                      |                          |
| 22b. SIGNATURE<br><i>Robert Kramer MD</i>   |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>10-6-1985</b>  |  |                      |                          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ROBERT KRAMER, M.D.</b>   |  | 22e. ADDRESS<br><b>10313 Georgia Ave., Silver Spring, Md. 20902</b>  |  |  |   |   |  |                      |                          |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>10-9-1985</b>  |  | 23c. NAME OF CEMETERY OR CREMATORIAL<br><b>King David Mem. Gdn</b>   |   | 23d. LOCATION<br>CITY OR TOWN<br><b>Falls Church, Va.</b>                           |  |                      |                          |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Danzansky-Goldberg Chapels; 1170 Rockville Pike</b>  |  | 23e. ADDRESS<br>23f. DATE REC'D. BY REGISTRAR<br><b>Oct. 14, 1985</b>  |  |  |   |   |  |                      |                          |
|   |  | 23g. REGISTRAR'S SIGNATURE<br><i>Julia Swanson</i>   |  |  |   |   |  |                      |                          |

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TO HOSPITAL or attending physician.  
retained by \_\_\_\_\_

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then leave room for carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| 1 - STATE REGISTRAR  |  |  |   | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH | REG. NO. 85 29095  |
|--|--|--|---|--|--|
| 1a. DECEASED NAME<br>(TYPE OR PRINT)   | FIRST<br>SAMUEL  | MIDDLE<br>KWASH  | LAST  | 2a. DATE OF DEATH<br>MONTH<br>OCTOBER 28, 1985<br>YEAR                               | 2b. HOUR<br>1:30A M  |
| 3. SEX<br>MALE   | 4. RACE<br>CAUCASIAN   | 5. DATE OF BIRTH<br>MONTH<br>FEB. 15, 1902<br>YEAR   | 6. AGE<br>IN YEARS LAST BIRTHDAY<br>83<br>YRS                       | 7. IF UNDER 1 YEAR<br>MONTHS<br>0<br>DAYS<br>0                                       | 8. IF UNDER 24 HRS<br>HOURS<br>0<br>MIN.<br>0  |
| 7b. BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)<br>ROMANIA   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED<br><input type="checkbox"/> NEVER MARRIED<br><input checked="" type="checkbox"/> WIDOWED<br><input type="checkbox"/> DIVORCED | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY COUNTY<br>MD.    |  |  |
| 10. CITY OR TOWN OF DEATH<br>WHEATON   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>MANOR CARE NURSING HOME | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>FURRIER  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>FUR                         |  |  |
| 13a. STATE<br>MARYLAND   | 13c. CITY OR TOWN<br>BALTO.  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  | 13e. STREET ADDRESS / ZIP CODE<br>4001 CLARKS LA., APT. 506 (21215) |  |  |
| 14. FATHER'S NAME<br>FIRST<br>SIMON  | MIDDLE<br>KWASH  | 15. MOTHER'S MAIDEN NAME<br>FIRST<br>LEAH  | MIDDLE<br>UNKNOWN   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>NO  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>216-32-5941   | 17. INFORMANT<br>HERBERT KWASH   | SILVER SPRING, MD<br>908 CADDINGTON AVE 20901                       |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>congestive heart failure</i>   |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                      |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>metabolic sarcopenia</i><br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause lost  |  |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>Kaposi's sarcoma</i>  |  |  |   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |   |  |  |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING<br><input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION<br>STREET  | CITY OR TOWN  | COUNTY   | STATE  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>one week</i> , to <i>10-28-85</i> , 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>10-26-85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |  |  |
| 22b. SIGNATURE<br><i>Robert Kramer MD</i>  | 22c. DEGREE  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>       | 22d. DATE SIGNED<br><i>10/28/85</i>                                 |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>ROBERT KRAMER</i>  | 22e. ADDRESS<br><i>10313 Georgia Ave 81188618</i>  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   | 23b. DATE<br>10-29-85  | 23c. NAME OF CEMETERY OR CREMATORIAL<br>FORBAND CEM  | 23d. LOCATION<br>CITY OR TOWN<br>ROSEDALE                           | COUNTY<br>BALTO.   | STATE<br>MARYLAND  |
| 24. FUNERAL DIRECTOR<br>NAME<br>SOL LEVINSON & BROS., INC.<br>ADDRESS<br>6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215   | 25a. DATE REC'D. BY REGISTRAR<br>OCT 31 1985   |  | 25b. REGISTRAR'S SIGNATURE<br><i>John L. Parker</i>                 |  |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 29096

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|  |  |  |   |  |   |  |  |                             |      |  |
|--|--|--|---|--|---|--|--|-----------------------------|------|--|
| 1. DECEASED NAME<br><small>(TYPE OR PRINT)</small>   |  |  |   | 2a. DATE OF DEATH                        | MONTH   | DAY  | YEAR   | 2b. HOUR                    |      |  |
| <b>NELLIE CURRAN LaFRANCE</b>  |  |  |   | <b>OCTOBER 29, 1985</b>                  |   |  |  | <b>11:30AM</b>              |      |  |
| 3. SEX   | 4. RACE  | 5. DATE OF BIRTH   |   | 6. AGE (IN YEARS LAST BIRTHDAY)          | IF UNDER 1 YEAR<br>MONTHS   | IF UNDER 24 HRS<br>DAYS  |  | 7. IF UNDER 24 HRS<br>HOURS | MIN. |  |
| FEMALE   | CAUCASIAN  | MONTH DAY YEAR<br><b>APRIL 11, 1891</b>  |   | 94                                       |   |  |  |                             |      |  |
| 7a. BIRTHPLACE<br><small>(STATE OR FOREIGN COUNTRY)</small>  | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED<br><input type="checkbox"/> NEVER MARRIED<br><input type="checkbox"/> WIDOWED<br><input checked="" type="checkbox"/> DIVORCED | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |   |  |  |                             |      |  |
| NEW YORK   | U.S.A.   | XX   | MONTGOMERY  |  |   |  |  |                             |      |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><small>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)</small> |  |   |  | 12a. USUAL OCCUPATION<br><small>(TYPE OF WORK FOR MOST OF WORKING LIFE)</small> | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                             |      |  |
| SILVER SPRING  | CIRCLE MANOR NURSING HOME  |  |   |  | HOUSEWIFE   |  |  |                             |      |  |
| 13a. STATE   | 13b. COUNTY  | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE           |   |  |  |                             |      |  |
| MARYLAND   | MONTGOMERY   | SILVER SPRING  | XX  | 9005 LINTON STREET                       | 20901   |  |  |                             |      |  |
| 14. FATHER'S NAME  | FIRST  | MIDDLE   | LAST  | 15. MOTHER'S MAIDEN NAME                 | FIRST   | MIDDLE   | LAST   |                             |      |  |
| JOHN   |  |  | CURRAN  | MARY                                     |   |  | LAVELLE  |                             |      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br><small>(YES, NO OR UNKNOWN)</small>  | 16b. SOCIAL SECURITY NO.   | 17. INFORMANT  | ADDRESS   |  |   |  |  |                             |      |  |
| NO   |  | MARTHA LaFRANCE KANE   | SAME AS 13 DAUGHTER   |  |   |  |  |                             |      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>ASPIRATION PNEUMONITIS</u>   |  |  |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>ONE WEEK</u> |                             |      |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>SENILE INANITION</u>  |  |  |   |  |   |  | <u>ONE YEAR</u>  |                             |      |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |  |   |  |   |  |  |                             |      |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.<br><u>GASTROINTESTINAL HEMORRHAGE, CEREBROVASCULAR INSUFFICIENCY, DEMERATION</u>   |  |  |   |  |   |  |  |                             |      |  |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                             |      |  |
|  |  |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |                             |      |  |
| 21a. ACCIDENT WAS UNDERLYING<br><small>OR CONTRIBUTING</small> <input type="checkbox"/> CAUSE OF DEATH<br><small>(IF EITHER, NOTIFY MEDICAL EXAMINER)</small>  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |   |  |  |                             |      |  |
| 21d. INJURY OCCURRED<br><small>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br/>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/></small>   | 21e. PLACE OF INJURY<br><small>(AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)</small>                                     | 21f. LOCATION<br>STREET  | CITY OR TOWN  | COUNTY                                   | STATE   |  |  |                             |      |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>SEPT 10 1984</u> to <u>10/29 1985</u> , that (1) (we) last<br>saw the deceased live on <u>10/23 1985</u> , and that in (my) our opinion death occurred on the date and hour and from the causes stated<br>above, (1) (we) did (did not) view the body after death. |  |  |   |  |   |  |  |                             |      |  |
| 22b. SIGNATURE<br><u>Martin C. Sharrel</u>   | DEGREE<br>M.D.   | ATTENDING PHYSICIAN <input type="checkbox"/>   | MEDICAL DIRECTOR <input type="checkbox"/>   | STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED<br><u>10/29/85</u>   |  |  |                             |      |  |
| 22d. PHYSICIAN'S NAME<br><small>(TYPE OR PRINT)</small>  | 22e. ADDRESS   | <u>3720 FARRAGUT AVE.<br/>KENSINGTON, MD - 20895</u>   |   |  |   |  |  |                             |      |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><small>(SPECIFY)</small>  | 23b. DATE<br><u>BURIAL</u> <u>10/31/85</u>   | 23c. NAME OF CEMETERY OR CREMATORIAL<br><u>ST. AGNES CEMETERY</u>  | 23d. LOCATION<br>CITY OR TOWN<br><u>SYRACUSE</u>  | 23e. COUNTY<br><u>ONONDAGO</u>           | 23f. STATE<br><u>NEW YORK</u>   |  |  |                             |      |  |
| 24. FUNERAL DIRECTOR<br>NAME   | 25a. DATE REC'D. BY REGISTRAR<br><u>FRANCIS J. COLLINS JR.</u><br><u>500 UNIV. BLVD., W.; SILVER SPRING, MD. 20901</u>   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Johanna Davidson-Randall</u>                   |  |  |                             |      |  |
| BP _____   |  |  |   |  |   |  |  |                             |      |  |
| DHMH - 16 60M 7/B4<br>(VRA 15, 4)  |  |  |   |  |   |  |  |                             |      |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|  |  |  |   |                  |           |   |                                |     |  |                 |       |  |  |  |
|--|--|--|---|------------------|-----------|---|--------------------------------|-----|--|-----------------|-------|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)   |  |  | FIRST   | MIDDLE           | LAST      | 20 DATE OF DEATH  | MONTH                          | DAY | YEAR   | 2b HOUR         |       |  |  |  |
| <i>Josephine Lamendola</i>   |  |  |   |                  | LAMENDOLA | 10  | 19                             | 85  | 6 08 PM  |                 |       |  |  |  |
| 3 SEX  |  |  | 4 RACE  | 5. DATE OF BIRTH |           |   | 6 AGE (IN YEARS LAST BIRTHDAY) |     |  | IF UNDER 1 YEAR |       | IF UNDER 24 HRS                                    |  |  |
| F  |  |  | CAUCASIAN   | MONTH            | DAY       | YEAR  | 86                             | YRS | MONTHS   | DAYS            | HOURS | MIN.   |  |  |
| 7a BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)   |  |  | 7b CITIZEN OF WHAT COUNTRY?   |                  |           | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |                                |     | 9 BALTIMORE CITY OR COUNTY OF DEATH  |                 |       |  |  |  |
| SICILY   |  |  | U.S.A.  |                  |           |   |                                |     | MONTGOMERY   |                 |       |  |  |  |
| 10 CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                  |           | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |                                |     | 12b KIND OF BUSINESS OR<br>INDUSTRY  |                 |       |  |  |  |
| KENSINGTON   |  |  | Kensington Gardens Nsg. Ctr.  |                  |           | SEAMSTRESS  |                                |     | 3600 BEL PRE ROAD  |                 |       |  |  |  |
| 13a STATE<br>MARYLAND  |  |  | 13b COUNTY<br>MONTGOMERY  |                  |           | 13c CITY OR TOWN<br>SILVER SPRING   |                                |     | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                 |       | 13e STREET ADDRESS / ZIP CODE                      |  |  |
| 14 FATHER'S NAME<br>FIRST  |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST  |                  |           | 16 SOCIAL SECURITY NO.  |                                |     | 17 INFORMANT   |                 |       | 18 APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |  |
| LUCIANO  |  |  | DISALVO   |                  |           | 154-07-9307   |                                |     | SON  |                 |       | 3501 CHERRY VALLEY,<br>OLNEY, MD. 20832            |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |  | 16b SOCIAL SECURITY NO.   |                  |           | 17 INFORMANT  |                                |     | ADDRESS  |                 |       |  |  |  |
| no   |  |  |   |                  |           | JOSEPH LAMENDOLA, JR.   |                                |     |  |                 |       |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY  |  |  | IMMEDIATE CAUSE (a)   |                  |           | DUE TO, OR AS A CONSEQUENCE OF<br>(b)   |                                |     | DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |                 |       |  |  |  |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause last.  |  |  |   |                  |           | coronary artery disease - cardiac   |                                |     |  |                 |       |  |  |  |
|  |  |  |   |                  |           | arachnoiditis - diabetes mellitus   |                                |     |  |                 |       |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><i>anemia - renal insufficiency</i>   |  |  |   |                  |           |   |                                |     |  |                 |       |  |  |  |
| 19a DATE OF OPERATION  |  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |                  |           | 20a AUTOPSY?  |                                |     | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                 |       |  |  |  |
|  |  |  |   |                  |           | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                |     |  |                 |       |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |                  |           | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |                                |     |  |                 |       |  |  |  |
| 21d INJURY OCCURRED<br>WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>   |  |  | 21e PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE FARM, ETC.)   |                  |           | 21f LOCATION<br>STREET  |                                |     | CITY OR TOWN   |                 |       | COUNTY   |  |  |
| 22a I certify that (I) (this hospital) attended the deceased from <i>Sept. 3rd 1985</i> , 1985, to <i>OCT. 21 1985</i> , that (I) (we) last<br>saw the deceased alive on <i>Sept. 3rd 1985</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) did not view the body after death. |  |  |   |                  |           |   |                                |     |  |                 |       |  |  |  |
| 22b SIGNATURE<br><i>José M. Solinas</i>  |  |  | DEGREE<br>M.D.  |                  |           | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |                                |     | 22c DATE SIGNED<br><i>10/21/85</i>   |                 |       |  |  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>José M. SOLINAS, M.D.</i>   |  |  | 22e ADDRESS<br><i>9801 GA. AV. S. SILVER SPRING, MD. 20902</i>  |                  |           |   |                                |     |  |                 |       |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  |  | 23b DATE<br>10/22/85  |                  |           | 23c NAME OF CEMETERY OR CREMATORIAL<br>PARKLAWN CEMETERY  |                                |     | 23d LOCATION<br>CITY/TOWN<br>ROCKVILLE   |                 |       | COUNTY<br>MONT                                     |  |  |
| 24 FUNERAL DIRECTOR<br>NAME <i>FRANCIS J. COLLINS, JR.</i><br>ADDRESS <i>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</i>   |  |  | 25a DATE RECD. BY REG. OFFICER<br><i>OCT 23 1985</i>  |                  |           | 25b REG. OFFICER'S SIGNATURE<br><i>[Signature]</i>  |                                |     |  |                 |       |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed by the attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completed, it should be detached from the burial/transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP \_\_\_\_\_  
DHMH - 16 60M 7/84  
(VRA 15, 4)

CEBUC



88700

309012

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8529098

1 - STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |                          |  |   |   |  |  |                          |  |                            |
|---|--|---|--|---|--------------------------|--|---|---|--|--|--------------------------|--|----------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   |  | FIRST   | MIDDLE                   | LAST   | 2a. DATE OF DEATH   | MONTH   | DAY  | YEAR   | 2b. HOUR                 |  |                            |
| Catherine S. Lane   |  |   |  |   |                          |  | October 31, 1985  |   |  |  | 2:30 am                  |  |                            |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |                          |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |   | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS          |  |                            |
| Female  |  | Caucasian   |  | MONTH   | DAY                      | YEAR   | 70  |   | MONTHS   | DAYS   | HOURS                    | MIN.   |                            |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED  |                          |  | NEVER MARRIED   |   | WIDOWED  |  | DIVORCED                 |  |                            |
| Maryland  |  | United States   |  | <input checked="" type="checkbox"/>                     | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/>  | <input type="checkbox"/>  | <input type="checkbox"/>                                 | <input type="checkbox"/>   | <input type="checkbox"/> |  |                            |
| 9. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |                          |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |   |  |  |                          | 12b. KIND OF BUSINESS OR<br>INDUSTRY                               |                            |
| Potomac   |  | 10301 Gary Road   |  |   |                          |  | Homemaker   |   |  |  |                          | own home   |                            |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |   |                          |  |   |   |  |  |                          |  |                            |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Montgomery   |  | 13c. CITY OR TOWN<br>Potomac                            |                          |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE<br>10301 Gary Road, 20854 |  |                          |  |                            |
| 14. FATHER'S NAME<br>FIRST  |  |   |  | MIDDLE  | LAST                     | 15. MOTHER'S MAIDEN NAME<br>FIRST  |   |   |  | MIDDLE   | LAST                     |  |                            |
| George  |  |   |  | Evans   | Sponsler                 | Julia  |   |   |  |  | Mallot                   |  |                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES) |                          |  | 17. INFORMANT   |   |  |  | ADDRESS                  |  |                            |
| no  |  |   |  | 212 05 4168   |                          |  | C. Walter Lane, Husband, see #13  |   |  |  |                          |  |                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>METASTATIC ENDOMETRIAL CANCER</u>   |  |   |  |   |                          |  |   |   |  |  |                          | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>9 months</u> |                            |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |   |  |   |                          |  |   |   |  |  |                          |  |                            |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |   |  |   |                          |  |   |   |  |  |                          |  |                            |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |  |   |                          |  |   |   |  |  |                          |  |                            |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |                          |  |   | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?                            |                          |  |                            |
| <input type="checkbox"/>  |  |   |  |   |                          |  |   | <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | <input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                          |  |                            |
| 21a. ACCIDENT WAS UNDERLYING<br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF FATHER NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |                          | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2) |   |   |  |  |                          |  |                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |                          | 21f. LOCATION<br>STREET  |   |   | CITY OR TOWN   | COUNTY   | STATE                    |  |                            |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>Feb 18</u> , 19 <u>80</u> , to <u>Oct 31</u> , 19 <u>85</u> , that (we) last saw the deceased alive on <u>Oct. 29, 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death. |  |   |  |   |                          |  |   |   |  |  |                          |  |                            |
| 22b. SIGNATURE<br><u>James A. Rossi MD</u>  |  |   |  |   |                          |  |   |   |  |  |                          | DEGREE   |                            |
| 22c. DATE SIGNED<br>October 31, 1985  |  |   |  |   |                          |  |   |   |  |  |                          |  |                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   | 22e. ADDRESS<br>6111 Executive Blvd., Rockville, MD 20852              |   |                          |  |   |   |  |  |                          |  |                            |
| James A. Rossi M.D.   |  |   |  |   |                          |  |   |   |  |  |                          |  |                            |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  |   | 23b. DATE  |   |                          | 23c. NAME OF CEMETERY OR CREMATORIAL   |   |   | 23d. LOCATION<br>CITY OR TOWN                            |  |                          | 23e. COUNTY  |                            |
| Cremation   |  |   | Oct. 31, 1985  |   |                          | Metropolitan Crematory   |   |   | Alexandria   |  |                          | Virginia   |                            |
| 24. FUNERAL DIRECTOR <u>Robert A. Pumphrey Funeral Homes,</u><br>NAME <u>P.A. 7557 Wisconsin Avenue, Bethesda, Maryland</u>   |  |   |  |   |                          |  |   |   |  |  |                          | 25a. DATE REC'D. BY REGISTRAR<br><u>NOV 01 1985</u>                | 25b. REGISTRAR'S SIGNATURE |
|   |  |   |  |   |                          |  |   |   |  |  |                          |  |                            |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, or by the physician or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial/transit permit. Then please remove carbon copy and return to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

S1000.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

297034

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 2 9 0 9 9

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|  |  |  |       |  |      |   |       |   |  |  |
|--|--|--|-------|--|------|---|-------|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  | FIRST | MIDDLE   | LAST | 2a. DATE OF DEATH<br>MONTH DAY YEAR   | MONTH | DAY   | YEAR   | 2b. HOUR<br>IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br>IF UNDER 24 HRS<br>MONTHS DAYS HOURS MIN. |
| FLORENCE S. LARKINS  |  |  |       |  |      | Oct. 13, 1985   |       |   |  | 8:36 A.M.  |
| 3. SEX<br>Female   |  | 4. RACE<br>Caucasian   |       | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>May 10, 1894   |      | 6. AGE (IN YEARS LAST BIRTHDAY)<br>91 YRS.  |       |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Ohio  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |       | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery  |       |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Silver Spring   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Holy Cross Hospital |       | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housemother  |      | 12b. KIND OF BUSINESS OR INDUSTRY<br>Univ. of Md.   |       |   |  |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Montgomery  |       | 13c. CITY OR TOWN<br>Wheaton   |      | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |       | 13e. STREET ADDRESS<br>11901 Georgia Avenue 20901 |  |  |
| 14. FATHER'S NAME<br>FIRST<br>Daniel   |  | MIDDLE<br>Strock   |       | LAST   |      | 15. MOTHER'S MAIDEN NAME<br>FIRST<br>Ada  |       | MIDDLE<br>Troutman                                |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>None   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>None  |       | 17. INFORMANT<br>Richard H. Larkins, Son, 44 Newriver Trace, 29701   |      | ADDRESS<br>Lake Wylie, S.C. 29701   |       |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>nude  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)   |  |  |       |  |      |   |       |   |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |       |  |      |   |       |   |  |  |
| (b)  |  |  |       |  |      |   |       |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br><i>Arteriosclerotic heart disease</i>  |  |  |       |  |      |   |       |   |  |  |
| (c)  |  |  |       |  |      |   |       |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br><i>unknown to years.</i>   |  |  |       |  |      |   |       |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a<br><i>Colon Cancer with lung metastasis diagnosed September 1985</i>  |  |  |       |  |      |   |       |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |       | 20a. AUTOPSY?  |      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?                                  |       |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)   |      | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                             |       |   | YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |       | 21f. LOCATION<br>STREET  |      | CITY OR TOWN  |       |   | COUNTY STATE   |  |
| 22a. I certify that (I) <input type="checkbox"/> attended the deceased from _____, 19 74, to 13 May 1985, that (I) <input type="checkbox"/> last saw the deceased alive on 8 Oct 1985, and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> did (did not) view the body after death. |  |  |       |  |      |   |       |   |  |  |
| 22b. SIGNATURE<br><i>Donald E. Dillon MD</i>   |  | DEGREE   |       | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                             |      | 22c. DATE SIGNED<br>14 Oct 85   |       |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DONALD E. DILLON, M.D.  |  | 22e. ADDRESS<br>2901 Olney Sandy Spring Rd., Olney, Maryland   |       |  |      |   |       |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation  |  | 23b. DATE<br>Oct. 15, 1985   |       | 23c. NAME OF CEMETERY OR CREMATORIAL<br>Chambers Crematory   |      | 23d. LOCATION<br>CITY OR TOWN<br>Riverdale, P.G.Cty., Maryland                                  |       | COUNTY STATE                                      |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>W.W.CHAMBERS CO., 8655 Georgia Ave. S.S. Ma. 20910   |  | ADDRESS  |       | 25a. DATE REC'D. BY REGISTRAR<br>18 1985   |      | 25b. REGISTRAR'S SIGNATURE<br><i>Susan Twilley-Dillon</i>                                       |       |   |  |  |



302038

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |        |                                      |   |   |  |                                      |                   | 85 29100  |        |                 |         |          |
|--|--|---|--------|--------------------------------------|---|---|--|--------------------------------------|-------------------|---|--------|-----------------|---------|----------|
|  |  |   |        |                                      |   |   |  |                                      |                   | REG. NO.  |        |                 |         |          |
| 1. FOR STATE REGISTRAR   |  | II. DECEASED NAME<br>(TYPE OR PRINT)  |        |                                      | FIRST   |   | MIDDLE   | LAST                                 | 2d. DATE OF DEATH |   | MONTH  | DAY             | YEAR    | 2d. HOUR |
|  |  | William   |        |                                      | N.  |   |  | Lawrence                             | October 21 1985   |   |        |                 | 9:00 PM |          |
| 3. SEX   |  | M. RACE   |        |                                      | 5. DATE OF BIRTH  |   |  | 6. AGE (IN YEARS LAST BIRTHDAY)      |                   | IF UNDER 1 YEAR                                 |        | IF UNDER 24 HRS |         |          |
| Male   |  | Caucasian   |        |                                      | Dec. 21, 1910   |   |  | 74                                   |                   | YRS   | MONTHS | DAYS            | HOURS   | MIN.     |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |        |                                      | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |                   | MD.   |        |                 |         |          |
| North Carolina   |  | United States   |        |                                      |   |   |  | Montgomery County                    |                   |   |        |                 |         |          |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |        |                                      | 12a. USUAL OCCUPATION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)   |   |  | 12b. KIND OF BUSINESS OR INDUSTRY    |                   |   |        |                 |         |          |
| Bethesda   |  | Suburban Hospital   |        |                                      | Director of Stockpile   |   |  | U.S. Government                      |                   |   |        |                 |         |          |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |        |                                      |   |   |  |                                      |                   | 13e. STREET ADDRESS / ZIP CODE                  |        |                 |         |          |
| 13a. STATE   |  | 13b. COUNTY   |        | 13c. CITY OR TOWN                    |   | 13d. INSIDE CITY LIMITS?  |  | 7119 Plantation Lane/20852           |                   |   |        |                 |         |          |
| Maryland   |  | Montgomery  |        | Rockville                            |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                                      |                   |   |        |                 |         |          |
| 14. FATHER'S NAME  |  | FIRST   | MIDDLE | LAST                                 | 15. MOTHER'S MAIDEN NAME  |   | FIRST  | MIDDLE                               | LAST              |   |        |                 |         |          |
|  |  | Cary  | Floyd  | Lawrence                             |   |   | Bessie   |                                      | Norris            |   |        |                 |         |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.  |        |                                      | 17. INFORMANT   |   | ADDRESS  |                                      |                   |   |        |                 |         |          |
| NO   |  | 577-36-1678   |        |                                      | Wilma C. Lawrence, same as #13  |   |  |                                      |                   |   |        |                 |         |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)  |  |   |        |                                      |   |   |  |                                      |                   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |        |                 |         |          |
| Respiratory Arrest   |  |   |        |                                      |   |   |  |                                      |                   | minutes   |        |                 |         |          |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |  |   |        |                                      |   |   |  |                                      |                   |   |        |                 |         |          |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) Chronic Obstructive Pulmonary Disease  |  |   |        |                                      |   |   |  |                                      |                   | years   |        |                 |         |          |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |   |        |                                      |   |   |  |                                      |                   |   |        |                 |         |          |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a<br>Cigarette Smoking   |  |   |        |                                      |   |   |  |                                      |                   |   |        |                 |         |          |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |        |                                      | 20a. AUTOPSY?   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                                      |                   |   |        |                 |         |          |
|  |  |   |        |                                      | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                                      |                   |   |        |                 |         |          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |        |                                      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |  |                                      |                   |   |        |                 |         |          |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |        |                                      | 21f. LOCATION<br>STREET   |   | CITY OR TOWN   |                                      | COUNTY            | STATE   |        |                 |         |          |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/21/85 to 19/85, and that in (my) (our) opinion death occurred on the date and hour from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |        |                                      |   |   |  |                                      |                   | 19/85 to 21 Oct 1985                            |        |                 |         |          |
| 22b. SIGNATURE<br>John SAI A M. DEGREE   |  |   |        |                                      |   |   |  |                                      |                   | 22c. DATE SIGNED<br>10/21/85                    |        |                 |         |          |
| 22d. PHYSICIAN'S NAME<br>(TYPE OR PRINT)   |  | 22e. ADDRESS  |        |                                      |   |   |  |                                      |                   |   |        |                 |         |          |
| Patricia Kellogg MD  |  | 809 Vers Mill Rd, Rockville, Md 20851   |        |                                      |   |   |  |                                      |                   |   |        |                 |         |          |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 23b. DATE   |        | 23c. NAME OF CEMETERY OR CREMATORIAL |   | 23d. LOCATION<br>CITY OR TOWN                                       |  | COUNTY                               |                   | STATE   |        |                 |         |          |
| Burial   |  | Oct. 24, 1985   |        | Cedar Hill Cemetery                  |   | Suitland  |  | Maryland                             |                   |   |        |                 |         |          |
| 24. FUNERAL DIRECTOR<br>NAME   |  | Robert A. Pumphrey Funeral Homes<br>7557 Wisconsin Ave. Bethesda, MD 20814                                |        |                                      | 25a. DATE REC'D. BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE                                     |                                      |                   |   |        |                 |         |          |
|  |  |   |        |                                      | Oct 25 1985   |   |  |                                      |                   |   |        |                 |         |          |

890508



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by you, it should be detached for use as the burial/transit permit. Then please return the carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event like medical treatment, please attach a separate sheet of paper.

308038

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 3 5 2 9 1 0

1 - FOR  
STATE  
REGISTRAR

|  |  |  |   |                           |   |  |                                 |  |  |                 |       |   |       |
|--|--|--|---|---------------------------|---|--|---------------------------------|--|--|-----------------|-------|---|-------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  | FIRST   | MIDDLE                    | LAST  | 2a. DATE OF DEATH  | MONTH                           | DAY  | YEAR   | 2b. HOUR        |       |   |       |
| Blair  |  |  |   |                           | Lee, III  | October 25, 1985   |                                 |  | 3:20 PM  |                 |       |   |       |
| 3 SEX  |  |  | 4 RACE  | 5. DATE OF BIRTH          |   |  | 6. AGE (IN YEARS LAST BIRTHDAY) |  |  | IF UNDER 1 YEAR |       |   |       |
| Male   |  |  | White   | May 19 1916               |   |  | 69                              |  |  | MONTHS          | DAYS  | IF UNDER 24 HRS                                 |       |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |  | 7b. CITIZEN OF WHAT COUNTRY?  |                           |   | 8  |                                 |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |                 |       | MD.   |       |
| Maryland   |  |  | USA   |                           |   | MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                 |  | Montgomery   |                 |       |   |       |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                           |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |                                 |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |                 |       |   |       |
| Silver Spring  |  |  | 400 Warrenton Drive   |                           |   | Retired-Governor of Md.  |                                 |  | 20501  |                 |       |   |       |
| 13a. STATE<br>Md.  |  |  | 13b. COUNTY<br>Mont.  | 13c. CITY OR TOWN<br>S.S. | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                                 | 13e. STREET ADDRESS<br>400 Warrenton Drive |  |                 |       |   |       |
| 14. FATHER'S NAME<br>FIRST<br>E.   |  |  | MIDDLE<br>Brooke  | LAST<br>Lee               | 15. MOTHER'S MAIDEN NAME<br>FIRST<br>Elizabeth  |  |                                 | MIDDLE                                     | LAST<br>Wilson   |                 |       |   |       |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES GIVE WAR OR DATES)<br>Yes Navy 215 26 0356                            |                           |   | 17. INFORMANT<br>Mathilde Lee (Wife) Same as 13e   |                                 |  | ADDRESS  |                 |       | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |       |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)  |  |  | Cardiorespiratory Arrest  |                           |   |  |                                 |  |  |                 |       | Immediate                                       |       |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |  |  | DUE TO, OR AS A CONSEQUENCE OF<br>b) Lung Cancer  |                           |   |  |                                 |  |  |                 |       | 1 Year 3 Months                                 |       |
| DUE TO, OR AS A CONSEQUENCE OF<br>c)   |  |  |   |                           |   |  |                                 |  |  |                 |       |   |       |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a   |  |  |   |                           |   |  |                                 |  |  |                 |       |   |       |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                           |   | 20a. AUTOPSY?  |                                 |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                 |       |   |       |
|  |  |  |   |                           |   | YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                 |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                 |       |   |       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                           |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                                 |  |  |                 |       |   |       |
| 21d. INJURY OCCURRED<br>AT WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |                           |   | 21f. LOCATION<br>STREET  |                                 |  | CITY OR TOWN   | COUNTY          | STATE |   |       |
| 22a. I certify that (I) (XX) attended the deceased from July 3, 1984, to October 25, 1985, that (I) (XX) last saw the deceased alive on September 27, 1985, and that in my (my) (XX) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |                           |   |  |                                 |  |  |                 |       |   |       |
| 22b. SIGNATURE<br><i>Bruce A. Silver, MD</i>   |  |  | DEGREE  |                           |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |                                 |  | 22c. DATE SIGNED<br>10/25/85                                   |                 |       |   |       |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Bruce A. Silver, M.D.   |  |  | 22e. ADDRESS<br>106 Irving Street N.W. Washington, D.C. 20010   |                           |   |  |                                 |  |  |                 |       |   |       |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |  | 23b. DATE<br>10/29/85   |                           |   | 23c. NAME OF CEMETERY OR CREMATORIAL<br>Rock Creek Cemetery Washington, D.C.   |                                 |  | 23d. LOCATION<br>CITY OR TOWN                                  |                 |       | COUNTY  | STATE |
| 24. FUNERAL DIRECTOR<br>NAME<br>Hines/Rinaldi  |  |  | ADDRESS<br>11800 New Hamp.Ave.S.S.Md.   |                           |   | 25a. DATE REC'D. BY REGISTRAR<br>Oct 31 1985   |                                 |  | 25b. REGISTRAR'S SIGNATURE<br>J                                |                 |       |   |       |
| BP _____   |  |  |   |                           |   |  |                                 |  |  |                 |       |   |       |
| DHMH-16 50M.1/B1<br>(VRA 15, 4)  |  |  |   |                           |   |  |                                 |  |  |                 |       |   |       |



287124

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |       |   |  |                   |  |  |  |   |            |  |      |
|---|--|---|-------|---|--|-------------------|--|--|--|---|------------|--|------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   | FIRST | MIDDLE  | LAST   | 2a. DATE OF DEATH | MONTH  | DAY  | YEAR   | 2b. HOUR  | PM         |  |      |
| C. Shepherd   |  |   |       |   | LEE  | October 4, 1985   |  |  |  | 8:50  |            |  |      |
| 3. SEX  |  | 4. RACE   |       | 5. DATE OF BIRTH  |  |                   | 6. AGE (IN YEARS LAST BIRTHDAY)                                  |  |  | IF UNDER 1 YEAR                                 |            |  |      |
| Male  |  | Caucasian   |       | MONTH   | DAY  | YEAR              | 68   | YRS.   | MONTHS   | DAYS  | HOURS MIN. |  |      |
| Feb. 23, 1917   |  |   |       |   |  |                   |  |  |  |   |            |  |      |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |       | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |  |                   | 9. BALTIMORE CITY OR COUNTY OF DEATH                             |  |  | MD.   |            |  |      |
| North Carolina  |  | USA   |       | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                    |  |                   | Montgomery County  |  |  |   |            |  |      |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |       |   |  |                   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  |  | 12b. KIND OF BUSINESS OR INDUSTRY               |            |  |      |
| Wheaton   |  | Manor Care Nursing Home - Wheaton   |       |   |  |                   | Analysis   |  |  | US Government                                   |            |  |      |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |       |   |  |                   |  |  |  |   |            |  |      |
| 13a. STATE  |  | 13b. COUNTY   |       | 13c. CITY OR TOWN   |  |                   | 13d. INSIDE CITY LIMITS?   |  |  | 13e. STREET ADDRESS / ZIP CODE                  |            |  |      |
| Maryland  |  | Pr George's   |       | Glenn Dale  |  |                   | YES <input checked="" type="checkbox"/>                          | NO <input type="checkbox"/>                        | 9805 Dubarry St. 20760   |   |            |  |      |
| 14. FATHER'S NAME<br>FIRST  |  | MIDDLE  |       | LAST  | 15. MOTHER'S MAIDEN NAME<br>FIRST  |                   |  | MIDDLE   |  |   | LAST       |  |      |
| Mack  |  |   |       | Lee   | Luretta  |                   |  |  |  |   | Hughes     |  |      |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.  |       | 17. INFORMANT   |  |                   | ADDRESS  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |            |  |      |
| YES   |  | WW II   |       | 577-09-9985   |  |                   | Elizabeth S. Lee   |  |  | Glenn Dale, MD 20769                            |            |  | 1 mo |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>hepatitis failure</u>   |  |   |       |   |  |                   |  |  |  |   |            |  |      |
| DUE TO, OR AS A CONSEQUENCE OF<br>{<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>1b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |   |       |   |  |                   |  |  |  |   |            |  |      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a  |  |   |       |   |  |                   |  |  |  |   |            |  |      |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |       |   |  |                   | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |   |            |  |      |
|   |  |   |       |   |  |                   | YES <input type="checkbox"/>                                     | NO <input checked="" type="checkbox"/>             | YES <input type="checkbox"/>                                   | NO <input checked="" type="checkbox"/>          |            |  |      |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |       |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |                   |  |  |  |   |            |  |      |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>9/23                            |       |   | 21f. LOCATION<br>STREET<br>CITY OR TOWN<br>COUNTY<br>STATE   |                   |  |  |  |   |            |  |      |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10/10/85</u> , 19 <u>85</u> , to <u>10/4/85</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>10/10/85</u> , 19 <u>85</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death. |  |   |       |   |  |                   |  |  |  |   |            |  |      |
| 22b. SIGNATURE<br><u>Myron L. Lenkin</u>  |  | DEGREE  |       |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> MEDICAL STAFF PHYSICIAN <input type="checkbox"/> |                   |  | 22c. DATE SIGNED<br>10/5/85                        |  |   |            |  |      |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Myron L. LENKIN</u>   |  | 22e. ADDRESS<br>2309 SHOREFIELD RD<br>WHEATON, MD 20902   |       |   |  |                   |  |  |  |   |            |  |      |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>Oct 7, 1985  |       | 23c. NAME OF CEMETERY OR CREMATORIAL<br>Maryland Veterans Cem.                        |  |                   | 23d. LOCATION<br>CITY OR TOWN<br>Cheltenham, Pr George's, MD     |  | STATE<br>COUNTY  |   |            |  |      |
| 24 FUNERAL DIRECTOR<br>NAME<br>Beall Funeral Home   |  | 16000 Annapolis Road<br>Bowie, MD 20715-3043  |       |   | 25a. DATE REC'D. BY REGISTRAR<br>OCT 9 1985  |                   |  | 25b. REGISTRAR'S SIGNATURE<br><u>John J. Beall</u> |  |   |            |  |      |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death.

Be executed within 24 hours of death. Page 4 may be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death.

rejoined by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon paper. Pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified of same.

1960-1961 - 1961-1962 - 1962-1963

1963-1964 - 1964-1965 - 1965-1966

1966-1967 - 1967-1968 - 1968-1969

1969-1970 - 1970-1971 - 1971-1972

1972-1973 - 1973-1974 - 1974-1975

1975-1976 - 1976-1977 - 1977-1978

1978-1979 - 1979-1980 - 1980-1981

1981-1982 - 1982-1983 - 1983-1984

1984-1985 - 1985-1986 - 1986-1987

1987-1988 - 1988-1989 - 1989-1990

1990-1991 - 1991-1992 - 1992-1993

1993-1994 - 1994-1995 - 1995-1996

1996-1997 - 1997-1998 - 1998-1999

1999-2000 - 2000-2001 - 2001-2002

2002-2003 - 2003-2004 - 2004-2005

2005-2006 - 2006-2007 - 2007-2008

2008-2009 - 2009-2010 - 2010-2011

2011-2012 - 2012-2013 - 2013-2014

294031

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST.

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS OF THE DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.

**PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 1A, 3, RETAIN PAGE 5 FOR YOUR FILES.**

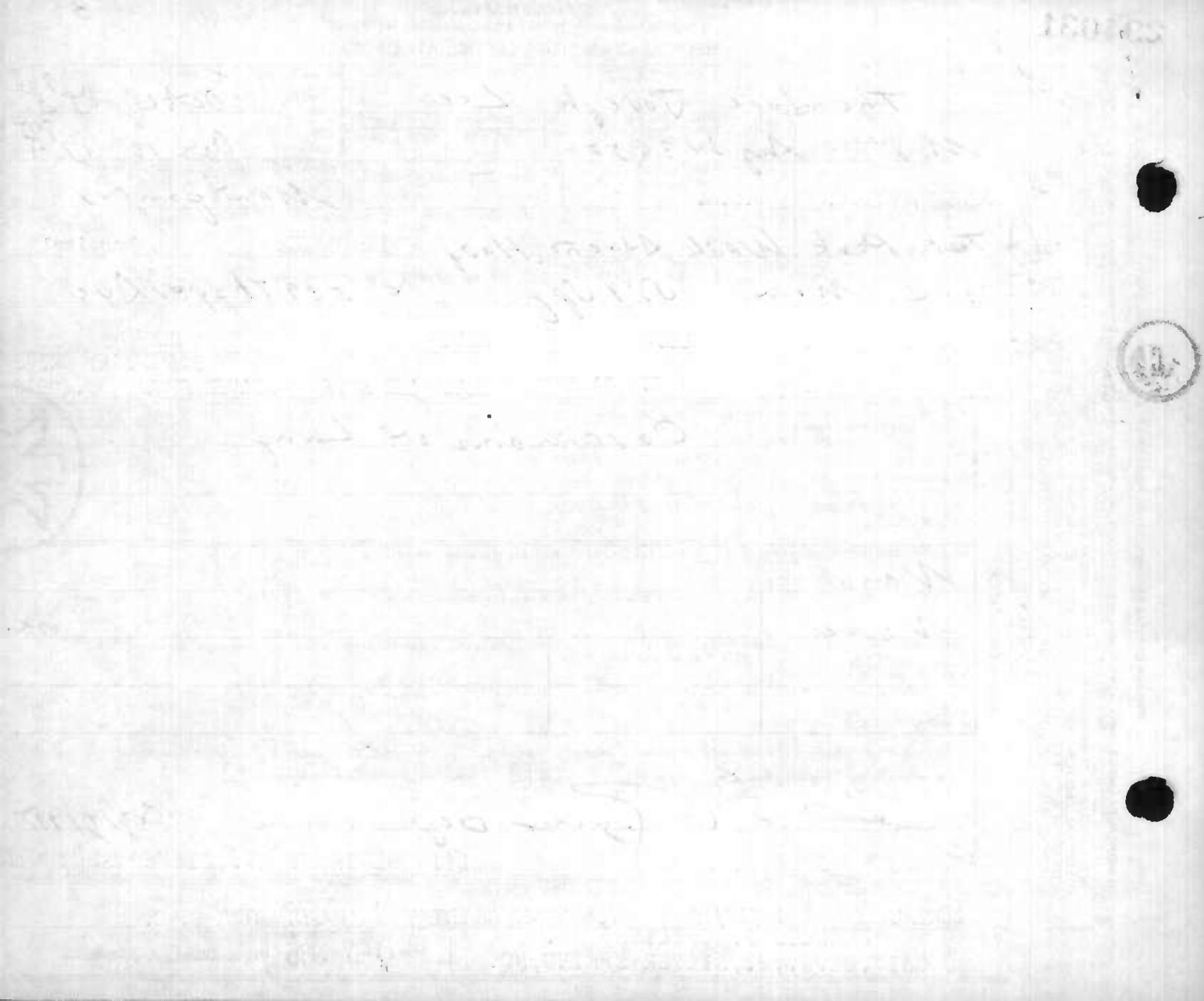
**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

29103

REG. NO.

|  |  |  |  |  |  |   |  |  |   |  |  |  |  |  |   |  |  |
|--|--|--|--|--|--|---|--|--|---|--|--|--|--|--|---|--|--|
| OR<br>STATE<br>REGISTRAR   |  |  | 29103  |  |  |   |  |  |   |  |  |  |  |  |   |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  | FIRST  |  |  | MIDDLE  |  |  | LAST  |  |  | 2a. DATE KNOWN<br>OF ESTI-<br>MATED<br>DEATH<br>MONTH DAY<br>YEAR  |  |  | 2b. DATE<br>PRONOUNCED<br>DEAD<br>MONTH DAY<br>YEAR |  |  |
| 3. SEX   |  |  | 4. RACE  |  |  | 5. DATE OF BIRTH<br>MONTH DAY<br>YEAR   |  |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY  |  |  | IF UNDER 1 YR.<br>MONTHS DAYS                                      |  |  | IF UNDER 24 HRS.<br>HOURS MIN.                      |  |  |
| M  |  |  | white  |  |  | Aug. 24 1936  |  |  | 55 yrs.   |  |  |  |  |  |   |  |  |
| 7a. BIRTHPLACE<br>(STATE OR<br>FOREIGN COUNTRY)  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  | 8   |  |  | MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>              |  |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                |  |  |
| WASHINGTON, D.C.   |  |  | U.S.A.   |  |  |   |  |  |   |  |  |  |  |  | Montgomery  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)              |  |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY  |  |  |  |  |  |   |  |  |
| Tak. Park Wash Advent Hosp   |  |  | ENGINEER   |  |  |   |  |  |   |  |  |  |  |  | MD.   |  |  |
| 13a. STATE   |  |  | 13b. COUNTY  |  |  | 13c. CITY OR TOWN   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  | 13e. STREET ADDRESS  |  |  |   |  |  |
| Md.  |  |  | Baltimore  |  |  | Baltimore   |  |  |   |  |  | 539 Thayer Ave   |  |  |   |  |  |
| 14. FATHER'S NAME<br>FIRST   |  |  | MIDDLE   |  |  | LAST  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST   |  |  | MIDDLE   |  |  | LAST  |  |  |
| JAMES  |  |  | E.   |  |  | LEE   |  |  | HELEN   |  |  |  |  |  | REGAN   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |  |  | 16b. SOCIAL SECURITY NO.   |  |  | 17. INFORMANT   |  |  | ADDRESS   |  |  |  |  |  |   |  |  |
| YES  |  |  | 1950-1953  |  |  | 578 34 1902   |  |  | DAUGHTER  |  |  | 506 EASLEY DRIVE   |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  | 18b. APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |  |   |  |  |   |  |  |  |  |  |   |  |  |
| PART I DEATH WAS CAUSED BY:  |  |  | IMMEDIATE CAUSE (a)  |  |  | DUE TO, OR AS A CONSEQUENCE OF  |  |  | (b)   |  |  | DUE TO, OR AS A CONSEQUENCE OF                                     |  |  |   |  |  |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a) stating the under-<br>lying cause last.   |  |  | (c)  |  |  | (c)   |  |  |   |  |  |  |  |  |   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |  |  |  |  |   |  |  |   |  |  |  |  |  |   |  |  |
| None   |  |  | 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                             |  |  | 20. AUTOPSY?  |  |  |  |  |  |   |  |  |
| None   |  |  | None   |  |  | None  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                             |  |  |  |  |  |   |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |  |   |  |  |  |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)   |  |  | 21f. LOCATION<br>STREET   |  |  | CITY OR TOWN  |  |  | COUNTY   |  |  | STATE   |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |  |  |   |  |  |   |  |  |  |  |  |   |  |  |
| TITLE (SPECIFY)<br><br>ACTUAL SIGNATURE <i>John S. Rogers</i> M.D., D.P.M. MEDICAL EXAMINER  |  |  |  |  |  |   |  |  |   |  |  |  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  |  | 23b. DATE  |  |  | 23c. NAME OF CEMETERY OR CREMATORIUM  |  |  | 23d. LOCATION<br>CITY OR TOWN   |  |  | 23e. COUNTY  |  |  | STATE   |  |  |
| BURIAL   |  |  | 10/17/85   |  |  | MT. OLIVET CEMETERY   |  |  | WASHINGTON, D. C.   |  |  |  |  |  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <i>FRANCIS J. COLLINS, JR.</i><br>ADDRESS <i>500 UNIV. BLVD., W., SILVER SPRING, MD.</i>  |  |  | 25a. DATE REC'D. BY REGISTRAR <i>Oct 17 1985</i>   |  |  | 25b. REGISTRAR'S SIGNATURE <i>Jeanne Davidson-Pondell</i>                     |  |  |   |  |  |  |  |  |   |  |  |



302012

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8529104

REG. NO.

1 - STATE  
REGISTRAR

|   |     |  |   |   |   |  |  |            |   |       |   |     |     |                                |                                |
|---|-----|--|---|---|---|--|--|------------|---|-------|---|-----|-----|--------------------------------|--------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |     |  | FIRST<br><b>Mary</b>  | MIDDLE<br><b>Elva</b>   | LAST<br><b>Leonard</b>  | 2a. DATE OF DEATH<br><b>October 20, 1985</b>   | MONTH<br>YEAR  | DAY        | 2b. HOUR<br><b>7:20 p.m.</b>  |       |   |     |     |                                |                                |
| 2. SEX  |     |  | 4. RACE<br><b>Female</b>  | White   | 5. DATE OF BIRTH<br>MONTH<br><b>April</b> DAY<br><b>12, 1909</b> YEAR                                       | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b>   | IF UNDER 1 YEAR<br>MONTHS  | DAYS       | IF UNDER 24 HRS<br>HOURS  | MIN.  |   |     |     |                                |                                |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)   |     |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |   | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b>  |            |   |       |   |     |     |                                |                                |
| 10. CITY OR TOWN OF DEATH<br><b>Kensington</b>  |     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><b>Circle Manor Nursing Home</b> |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired Dietician</b>   |  |            | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br><b>Montgomery Co.<br/>Schools</b> |       |   |     |     |                                |                                |
| 13a. STATE<br><b>Maryland</b>   |     |  | 13b. COUNTY<br><b>Montgomery</b>  | 13c. CITY OR TOWN<br><b>Silver Spring</b>                                 | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             | 13e. STREET ADDRESS / ZIP CODE<br><b>4401 Fernhall Road 20906</b>  |  |            |   |       |   |     |     |                                |                                |
| 14. FATHER'S NAME<br>FIRST<br><b>Mark</b>   |     |  | MIDDLE<br><b>Nidiffer</b>   | LAST  | 15. MOTHER'S MAIDEN NAME<br><b>Molly</b>  | MIDDLE<br><b>Scafe</b>   |  |            |   |       |   |     |     |                                |                                |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>NO  |     |  | 16b. SOCIAL SECURITY NO.<br><b>579-22-4525</b>  |   |   | 17. INFORMANT<br><b>Potomac, Md. 20854</b><br><b>Donna M. Mitchell 11620 Beall Mountain Rd.</b>  |  |            | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>YEARS</b>           |       |   |     |     |                                |                                |
| <p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br/> <b>PART I. DEATH WAS CAUSED BY</b><br/> <b>IMMEDIATE CAUSE (a) CHRONIC OBSTRUCTIVE LUNG DISEASE</b> </p> <table border="0" style="margin-left: 100px;"> <tr> <td>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.</td> <td rowspan="3" style="vertical-align: middle; padding: 0 10px;">(b)</td> <td rowspan="3" style="vertical-align: middle; padding: 0 10px;">(c)</td> </tr> <tr> <td style="padding: 0 10px;">DUE TO, OR AS A CONSEQUENCE OF</td> </tr> <tr> <td style="padding: 0 10px;">DUE TO, OR AS A CONSEQUENCE OF</td> </tr> </table> |     |  |   |   |   |  |  |            |   |       | Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. | (b) | (c) | DUE TO, OR AS A CONSEQUENCE OF | DUE TO, OR AS A CONSEQUENCE OF |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.   | (b) | (c)  |   |   |   |  |  |            |   |       |   |     |     |                                |                                |
| DUE TO, OR AS A CONSEQUENCE OF  |     |  |   |   |   |  |  |            |   |       |   |     |     |                                |                                |
| DUE TO, OR AS A CONSEQUENCE OF  |     |  |   |   |   |  |  |            |   |       |   |     |     |                                |                                |
| <p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</p>   |     |  |   |   |   |  |  |            |   |       |   |     |     |                                |                                |
| 19a. DATE OF OPERATION  |     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?   |            |   |       |   |     |     |                                |                                |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |     | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                               |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> |            |   |       |   |     |     |                                |                                |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>   |     | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET   |  | CITY OR TOWN   |            | COUNTY  | STATE |   |     |     |                                |                                |
| <p>22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>9/18/85</b>, to <b>10/20/85</b>, that (1) <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>10/5/85</b>, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. (1) <input type="checkbox"/> (we) did <input type="checkbox"/> (did not) view the body after death.</p>  |     |  |   |   |   |  |  |            |   |       |   |     |     |                                |                                |
| 22b. SIGNATURE<br><i>Martin C. Sharbel</i>  |     | 22c. DEGREE<br><b>M.D.</b>   |   |   | 22d. ATTENDING PHYSICIAN<br><input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN |  | 22e. DATE SIGNED<br><b>10/21/85</b>  |            |   |       |   |     |     |                                |                                |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MARTIN C. SHARBEL</b>   |     | 22e. ADDRESS<br><b>3720 FARRAGUT DR<br/>KENSINGTON, MARYLAND 20895</b> |   |   |   |  |  |            |   |       |   |     |     |                                |                                |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |     | 23b. DATE<br><b>10/23/85</b>   |   | 23c. NAME OF CEMETERY OR CREMATORIAL<br><b>George Washington Cemetery</b> |   | 23d. LOCATION<br>CITY OR TOWN<br><b>Adelphi, Maryland</b>  |  | 23e. STATE |   |       |   |     |     |                                |                                |
| 24. FUNERAL DIRECTOR<br><b>Tyson Wheeler Funeral Home, Inc.</b><br><b>1331 Rockville Pike, Rockville, Maryland 20852</b>  |     | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 25 1985</b>                    |   | 25b. REGISTRAR'S SIGNATURE<br><i>Davidson Randle</i>                      |   |  |  |            |   |       |   |     |     |                                |                                |

TO HOSPITAL OR ATTENDING PHYSICIAN.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician it should be detached for use as the burial-transit permit. Then please remove carbon paper. Boxes 1 and 2 should be filled within 7½ hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

CLOSED

TOP SECRET

REF ID:

SP-1

100

b6

SECRET

CD

SITE

initials

code

SECRET



SECRET

TO HOSPITAL ATTENDING PHYSICIAN The law requires that the death certificate be signed by the attending physician or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician it must be completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copy of pages 1 and 2 should be held within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT If item 21 is marked or item 18 shows any injury, or other trauma, even the medical examiner may be called.

311097

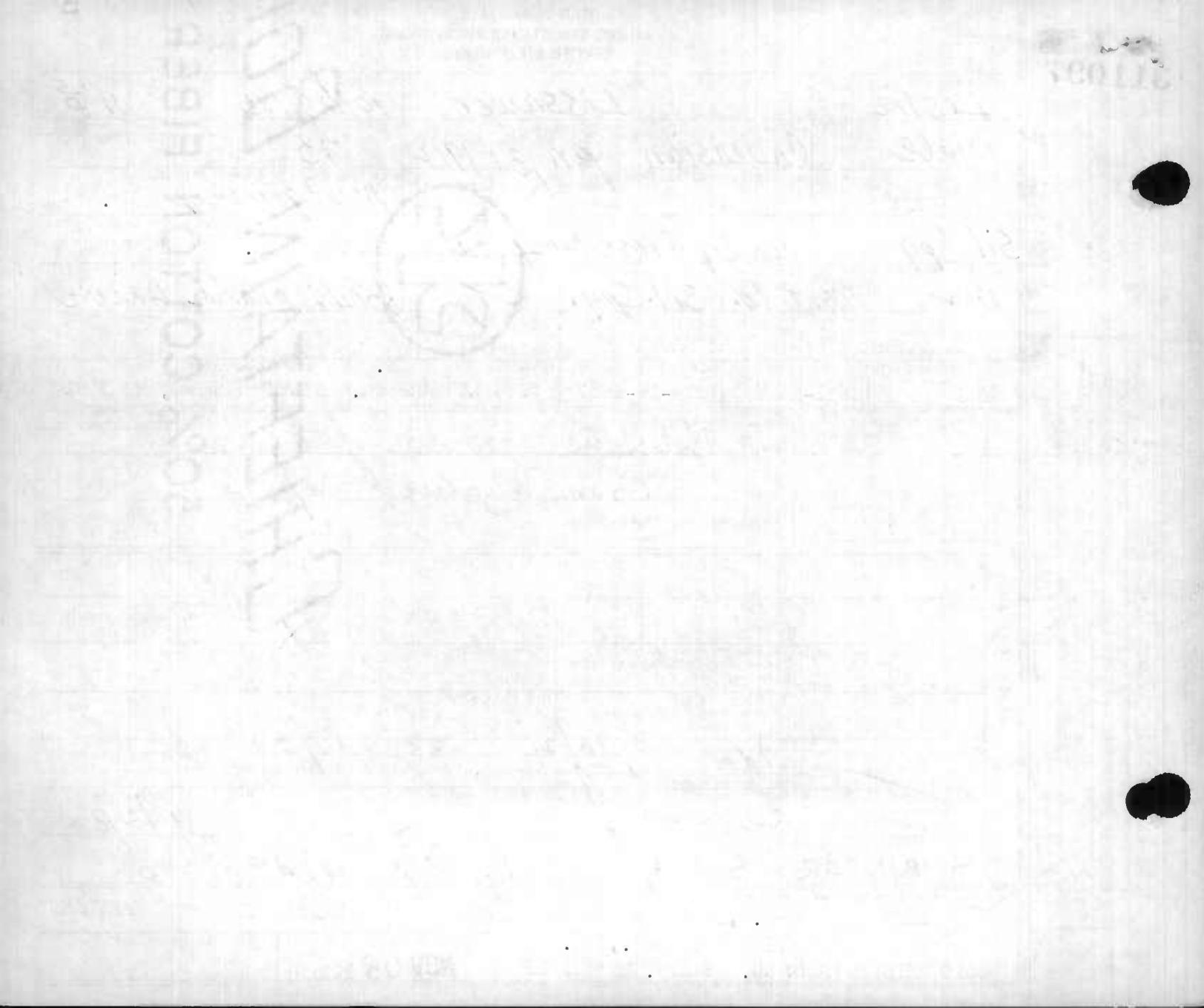
85 29105

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|  |           |  |                                      |   |   |  |   |                                   |                    |          |
|--|-----------|--|--------------------------------------|---|---|--|---|-----------------------------------|--------------------|----------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |           |  | FIRST                                | MIDDLE  | LAST  | 2a. DATE OF DEATH                      | MONTH   | DAY                               | YEAR               | 2b. HOUR |
| Leslie   |           |  |                                      |   | Lissauer  | 10/29/85                               |   |                                   |                    | 11 45    |
| SEX  | 4 RACE    | 5. DATE OF BIRTH   |                                      |   | 6 AGE (IN YEARS LAST BIRTHDAY)  | IF UNDER 1 YEAR                        | IF UNDER 24 HRS   |                                   |                    |          |
| male   | Caucasian | Jan 31 1912  |                                      |   | 73  | MONTHS                                 | DAYS  | HOURS                             | MIN.               |          |
| 7c. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |           | 7b. CITIZEN OF WHAT COUNTRY?   |                                      |   | 9 BALTIMORE CITY OR COUNTY OF DEATH   |  |   |                                   |                    |          |
| HUNGARY  |           | USA  |                                      |   | MARRIED <input checked="" type="checkbox"/>                                   | NEVER MARRIED <input type="checkbox"/> | WIDOWED <input type="checkbox"/>                                    | DIVORCED <input type="checkbox"/> | Montgomery CO. MD. |          |
| 10. CITY OR TOWN OF DEATH  |           | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  |                                      |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)              |  |   |                                   |                    |          |
| Sil Spring   |           | Navy Cross Hospital  |                                      |   | DENTAL TECH.  |  |   |                                   |                    |          |
| 13. USUAL RESIDENCE IF DIFFERENT FROM PLACE OF DEATH   |           | 14. STATE OR OTHER INSTITUTION ONE RESIDENCE BEFORE ADMISSION:   |                                      |   | 15. STREET ADDRESS / ZIP CODE   |  |   |                                   |                    |          |
| Md   |           | 15. COUNTY   | 16. CITY OR TOWN                     | 17. INSIDE CITY LIMITS?   | 18. APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                           |  |   |                                   |                    |          |
|  |           | Mont. Co.  | Sil. Spg.                            | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |   |                                   |                    |          |
| 16a. FATHER'S NAME   |           | FIRST  | MIDDLE                               | LAST  | MARY  | MIDDLE                                 | KOHN  | LAST                              |                    |          |
| ALEXANDER  |           |  |                                      |   |   |  |   |                                   |                    |          |
| 16b. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |           | 16b. SOCIAL SECURITY NO.   |                                      |   | 17. INFORMANT   |  |   |                                   |                    |          |
| YES  |           | WWII-ARMY  |                                      |   | MRS. SYLVIA LISSAUER  |  |   |                                   |                    |          |
|  |           | 214-16-5637  |                                      |   | 5504 LEONARD DR. SILVER SPRING, MD 20910                                      |  |   |                                   |                    |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY.  |           | IMMEDIATE CAUSE (a)  |                                      |   | Metastatic Carcinoma of the Colon   |  |   |                                   |                    |          |
|  |           | DUE TO, OR AS A CONSEQUENCE OF<br>{ (b) _____<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause last. |                                      |   | Gram Negative Sepsis  |  |   |                                   |                    |          |
|  |           | DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |                                      |   |   |  |   |                                   |                    |          |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a  |           |  |                                      |   |   |  |   |                                   |                    |          |
| 19a. DATE OF OPERATION   |           | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                      |   | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?   |                                   |                    |          |
|  |           |  |                                      |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   |                    |          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |           | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |                                      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |   |                                   |                    |          |
| 21d. INJURY OCCURRED<br>WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>  |           | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |                                      |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |   |                                   |                    |          |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/21, 1985, to 10/29, 1985, that (I) (we) last saw the deceased alive on 10/29, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |           |  |                                      |   |   |  |   |                                   |                    |          |
| 22b. SIGNATURE   |           | DEGREE   |                                      |   | 22e. DATE SIGNED  |  |   |                                   |                    |          |
| Surinder Singh   |           |  |                                      |   | 10/30/85  |  |   |                                   |                    |          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |           | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |                                      |   | 22e. ADDRESS  |  |   |                                   |                    |          |
| SURINDER SINGH M.D.  |           |  |                                      |   | 4713 Berwyn Rd.<br>College Park MD 20740                                      |  |   |                                   |                    |          |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |           | 23b. DATE  | 23c. NAME OF CEMETERY OR CREMATORIAL |   |   | 23d. LOCATION                          |   | 23e. COUNTY                       |                    |          |
| BURIAL   |           | NOV. 3, 1985   | BALTIMORE HEBREW                     |   |   | BALTIMORE                              |   | MARYLAND                          |                    |          |
| 24. FUNERAL DIRECTOR<br>NAME<br>ADDRESS  |           | 25a. DATE REC'D. BY REGISTRAR  |                                      |   | 25b. REGISTRAR'S SIGNATURE  |  |   |                                   |                    |          |
| SOL LEVINSON & BROS., INC.<br>6010 REISTERSTOWN RD. BALTO. MD 21215  |           | NOV 05 1985  |                                      |   |   |  |   |                                   |                    |          |



289096

TO HOSPITAL OR CLINIC: The law requires that the death certificate be executed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |   |  |  |                                |  |   |                   |                                   |  |
|---|--|---|--|---|--|--|---|--|--|--------------------------------|--|---|-------------------|-----------------------------------|--|
| REG. NO. 8 3 2 7 1 6  |  |   |  |   |  |  |   |  |  |                                |  |   |                   |                                   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   | FIRST MIDDLE   |   |  | LAST   |   |  | 2a. DATE OF DEATH MONTH DAY YEAR   |                                |  | 2b. HOUR  |                   |                                   |  |
| MARY  |  |   |  |   |  | LEVITT   |   |  | 10 03 85   |                                |  | 8P. M   |                   |                                   |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  |  | IF UNDER 1 YEAR                |  | IF UNDER 24 HRS   |                   |                                   |  |
| FEMALE  |  | WHITE   |  | MONTH DAY YEAR  |  |  | MONTH DAYS  |  |  | MONTHS DAYS                    |  | HOURS MIN.  |                   |                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |  |                                |  |   |                   |                                   |  |
| NEW YORK  |  | U.S.A.  |  | SEPTEMBER 12, 1905  |  |  | MONTGOMERY COUNTY MD.   |  |  |                                |  |   |                   |                                   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  |  |   |  |  |                                |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |                   | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| ROCKVILLE   |  | HEBREW HOME OF GREATER WASHINGTON   |  |   |  |  |   |  |  |                                |  | HOUSEWIFE   |                   | OWN HOME                          |  |
| 13a. STATE  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET ADDRESS / ZIP CODE |  | 20853   |                   |                                   |  |
| MARYLAND  |  | MONTGOMERY  |  | ROCKVILLE   |  |  |   |  |  | 12614 VIERS MILL ROAD          |  |   |                   |                                   |  |
| 14. FATHER'S NAME   |  | FIRST MIDDLE  |  | LAST  |  |  | 15. MOTHER'S MAIDEN NAME  |  |  | FIRST MIDDLE                   |  | LAST  |                   |                                   |  |
| LOUIS   |  |   |  | ROSENBLATT  |  |  | IDA   |  |  |                                |  | BENJAMIN  |                   |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.<br>(# YES, GIVE WAR OR DATES)  |  | 16c. INFORMANT  |  |  | 17. APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |  |                                |  |   |                   |                                   |  |
| NO  |  | 089-14-5000   |  | MORRIS J. LEVITT,   |  |  | 8908 LAKECREST DRIVE<br>GREENBELT, MARYLAND   |  |  | 2 MONTHS                       |  |   |                   |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and 1c.)<br>PART 1: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) METASTATIC CANCER  |  |   |  |   |  |  |   |  |  |                                |  |   |                   |                                   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) PRIMARY BREAST CARCINOMA  |  |   |  |   |  |  |   |  |  |                                |  |   |                   |                                   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) —   |  |   |  |   |  |  |   |  |  |                                |  |   |                   |                                   |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).<br>—  |  |   |  |   |  |  |   |  |  |                                |  |   |                   |                                   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                |  | 20b. IF YES, WERE FINDINGS USED<br>IN DETERMINING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                   |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |   |  |  |                                |  |   |                   |                                   |  |
| 21d. INJURY OCCURRED<br>WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET  |   |  | CITY OR TOWN   |                                |  | COUNTY  | STATE             |                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/19/85 to 10/3/85, that (I) (we) last saw the deceased alive on 10/3/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |   |  |  |                                |  |   |                   |                                   |  |
| 22b. SIGNATURE<br><i>D.D. Patel.</i>  |  |   | DEGREE<br>M.D.   |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  | 22c. DATE SIGNED<br>10/4/85  |                                |  |   |                   |                                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>D.D. PATEL   |  |   | 22e. ADDRESS<br>6121 MONTROSE RD Rockville, MD                         |   |  |  |   |  |  |                                |  |   |                   |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  |   | 23b. DATE<br>10/6/1985   |   |  | 23c. NAME OF CEMETERY OR CREMATORIUM<br>UNION FIELD CEMETERY   |   |  | 23d. LOCATION<br>CITY OR TOWN<br>BROOKLYN  |                                |  | COUNTY  | STATE<br>NEW YORK |                                   |  |
| 24. FUNERAL HOME<br>NAME<br>DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME<br>ADDRESS<br>232 CARROLL STREET, N. W., WASHINGTON, D. C.   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 8 1985  |   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Julia Friedman</i>                                  |                                |  |   |                   |                                   |  |

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